THE DEVELOPMENT AND PRACTICE OF CLINICAL TEACHING

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ABSTRACT

In this thesis an analysis of a particular method of generating theory incorporates studies of the development of clinical nurse teaching and of some selected aspects of its practice.

The process by which the analysis, comparison and coding of data started to generate theoretical categories and made it possible to refine and define the central issues and to identify relevant propositions and tentative theory as they emerged from the data is made explicit at each stage.

Preliminary reading and exploratory fieldwork showed that some clinical teachers were not doing what they thought 'ought' to be done. This raised the questions of whether there is a generally accepted prescription of what clinical teachers 'ought' to be doing, and of what they actually do.

An historical study considered critically the circumstances which gave rise to clinical teaching by a methodical examination of the creation of this grade of nurse teacher. In doing so it demonstrated the lack of conceptual consistency in nursing and nursing education, showing that clinical teaching developed in a somewhat haphazard fashion without any clear framework or basis for its practice. Indeed, two prescriptions, or 'ideal models' of clinical teaching emerged.

An observational study of practising clinical teachers demonstrated that many of the potential and actual problems which had been recognised at the inception of clinical teaching have not yet been resolved.

These data suggest that the ways in which clinical teaching is organised and implemented are a result of a possible correspondence between the organisational framework and the ideal models held by the clinical teacher and her educational manager. The final section of the thesis describes and discusses a second empirical study designed to test an hypothesis derived from this tentative theory.

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GLOSSARY

During the period covered in the historical section of the thesis there have been a number of changes in titles and terminology. For example, the 'nurse teacher' has been known as 'sister tutor' and 'nurse tutor' and the 'clinical nurse teacher' was until 1968 a 'clinical instructor' while the accepted title for the nurse in charge of a ward is now 'charge nurse'.

To avoid confusion the same titles have been used for each grade throughout the thesis irrespective of the term which was in use at the time, i.e. 'clinical teacher', 'nurse tutor' and 'ward sister'.

Similarly the title 'Royal College of Nursing' has been used throughout although for part of the period this body's formal title was 'the Royal College of Nursing and National Council of Nurses of the United Kingdom'.

In most cases titles have been used in full but where this would have been unduly cumbersome the following abbreviations have been used:

C.M.B.	Central Midwives Board
D.H.S.	Department of Health for Scotland which, in 1962, became
S.H.H.D.	Scottish Home and Health Department
D.H.S.S.	Department of Health and Social Security
G.N.C.	General Nursing Council
M.O.H.	Ministry of Health - the forerunner of the D.H.S.S.
Rcn	Royal College of Nursing
U.K.C.C.	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

It was the policy of the former General Nursing Council for Scotland to combine hospital schools of nursing

to form colleges. With the inclusion of the midwifery schools in recent years these are all now colleges of nursing and midwifery. At the time of writing there have been no 'schools of nursing' in Scotland for many years, but in England there are many such schools and very few 'colleges' of nursing. In the text the terms 'school of nursing' and 'college of nursing' are used interchangeably.

Throughout the thesis the convention of referring to all nurses as 'she' or 'her' has been used.

INTRODUCTION

CHAPTER ONE

AN INTRODUCTION TO SOME FUNDAMENTAL QUESTIONS OF METHODOLOGY

The search for knowledge follows established traditions and rules which can usually be recognised quite easily, although they may vary in different disciplines. This is particularly apparent in the predictable pattern of most final reports, dissertations or theses arising from empirical investigations. Most writers accept the advice found in any reputable introductory text on research methods, namely that "theses and dissertations are usually divided into six chapters: formulation of the problem, review of the literature, hypotheses, design and conduct of the study, analysis of data, and conclusion".(1) Although the research process itself may have been considerably less 'tidy' than this conventional format suggests, it will generally reflect the order in which the study was carried out.

Research which is traditionally reported in this way can be thought of as having three phases: conceptual, empirical and interpretative. The research proceeds in a relatively orderly fashion from the conceptualisation of the problem, through the gathering, ordering, and analysis of data to the interpretation of the findings in relation to the hypotheses, questions or purposes which guided the investigation. The character of the study, that is, the kind of data which will be sought, the methods which will be used to obtain them and the analytical procedures to which they will be subjected, is determined by the chosen conceptual framework. The conceptual elements are derived from existing knowledge about the phenomena to be studied, based on accumulated facts which

are already organised and analysed, available general theories that seem to be relevant, and appropriate portions of the larger body of knowledge in the relevant disciplines.

The conceptual phase, then, has four elements: the topic to be addressed by the study, the knowledge that exists about the aspect of the topic with which the study will be concerned, the investigator's mapping out of the topic in the light of that knowledge, and the specific hypotheses which are to be examined or tested in the empirical phase of the study.(2,3,4) The knowledge and theories on which the conceptualisation is based are taken as given. The empirical and interpretative stages of the research are directed to testing the hypotheses which are derived from them and the whole process can be illustrated by a linear model.

'theory' → formulation of hypotheses → collection of data → testing of hypotheses → interpretation

This approach accords with the commonly held view of the relationship of knowledge or 'theory' of practice which can also be conceived as a linear progression.

knowledge or 'theory' → application → practice

In disciplines which are rich in established theory this approach gives rise to few problems, but this is not so in disciplines which are still in the process of developing their theory, or when knowledge of the phenomena to be studied is sparse. Faced with these situations the investigator must either 'borrow' the knowledge and assumptions of another discipline or, by starting the research at a preconceptual stage, adopt an alternative approach which takes practice as the starting point and

seeks to develop new theory from it. Again, a linear model can be used to illustrate the process.

practice ⟶ analysis ⟶ theory ⟶ refined practice.

In nursing, as in many of the 'practice disciplines', it is often the first alternative, in which a problem is conceptualised within the framework of a basic or parent discipline which is chosen. However, this approach has a number of serious limitations. In the first place, theories and principles which are perfectly acceptable in the parent discipline may prove to be invalid or inappropriate when applied to another one. This is not to imply that insights from other disciplines cannot be helpful, but it should not be too readily assumed that they will 'fit'. Neither should it be assumed that the problem must be defined in such a way as to ensure that they do fit; an approach which Gouldner has likened to "carrying bones from an old graveyard to a new one." (5) Secondly, even when a 'fit' is not contrived there is a danger that the problem will be identified as a question from the parent discipline and will then be used as a vehicle for testing hypotheses relevant to that discipline. Finally, there is a strong possibility that the findings from a study using this alternative will advance knowledge in the discipline which provided the framework rather than in the practice discipline.

Many writers commenting on these limitations with respect to nursing research have suggested that the development of <u>nursing</u> theory is imperative if nurses are to function as <u>nurse</u> researchers rather than as researchers in other disciplines (e.g. 6-10). How can this be achieved?

Wald and Leonard suggest that "An alternative ..... is to begin with practical nursing experience and develop concepts from an analysis of that experience rather than to try to make borrowed concepts fit" (11). It is this alternative of generating theory from empirical data that has been chosen as the basis of the present study. A number of studies in nursing and in other disciplines have used this approach, which, following Glaser and Strauss (12), has come to be known as the "grounded theory" approach, but in most cases little information has been given as to how the method was used and the way in which concepts, methods and theory emerged from the data. An attempt has been made to remedy this lack in the following pages.

This thesis, therefore, serves two purposes. It is a report of a study of a substantive area, clinical nurse teaching, and it provides an analysis of a particular method of generating theory. These two purposes are not separate. The empirical studies took the form that they did as a direct result of the method used to generate theory, while the theory itself emerged from the empirical data.

The thesis consists of four parts.

Part one describes the substantive area to be studied and sets out the problems which gave rise to the study. It deals with the exploratory fieldwork and discusses the approach and method used in some detail.

Part two reports an historical study which was designed to answer one of the major questions raised in part one.

Part three first describes and discusses an empirical study designed to answer the second of the questions raised in part one and then describes the way in which a proposition emerged from these data.

Part four describes and discusses a second empirical study which was designed to test the proposition and attempts to draw together the threads from the other three parts.

First, however, it is necessary to describe in more detail the rationale which underlies this approach and the methods which have been used. This is done by attempting to answer three questions, namely, what is theory, how are 'theories' developed, and, how is 'grounded theory' generated?

What is theory?

The term 'theory' is used both loosely and specifically and may carry a variety of meanings. Melia (13), for example, has suggested that one of its uses in sociology is to refer to the writings of the classical sociologists such as Weber, Durkheim and Marx, the implication being that those writings provide the body of knowledge from which much of the work of later sociologists is derived. In other disciplines, too, the term is used in this way to refer to the whole abstract body of knowledge on which the discipline is founded.

Used in this sense the term is often contrasted or combined with the term 'practice' to suggest the conceptual or speculative rather than the concrete aspects of a topic, as, for example, in the phrase 'the theory and practice of nursing'. Unfortunately, however, in nursing, 'theory' has been narrowed even further and has come to be associated with the formal teaching of nursing care and techniques in a classroom setting as opposed to the care which is given in the wards 'in practice'. In this usage 'theory' is all too often "considered to have nothing in common with the real world". (14)

Another everyday use of the term is implied by the phrase 'I have a theory about that'. Here the term refers to ideas or 'concepts' which have been ordered in such a way as to provide an explanation for an event or relationship. In its precise and 'scientific' form, this use requires both abstraction and systematic ordering, so that in this sense a theory is a way of conceptualising, and also of ordering concepts, which corresponds with situations which can be observed in the real world and which can provide understanding and

explanation of that part of the real world to which it corresponds. It is in this sense that the term will be used here.

The choice of words is important. In the first place a theory is a conceptualisation. That is to say, all of its elements are at a conceptual level, although their level of abstraction and their relationship to each other will depend on the purpose which the theory serves. Secondly, a theory is systematic in that its elements are related in such a way as to produce a coherent framework or structure. Thirdly, a theory enables us to think about reality. It is important in this connection to realise that a theory is not itself reality, although it corresponds to reality. Rather it is a tool which structures thought, and may be used to describe, explain or shape reality.(15,16) Just as a tool would not be equated with the material it is used to shape, so a theory, even a grand theory, should not be expected to encompass the whole of reality. The best that can be expected is that the theory will explain that part of reality which comes under scrutiny, but in most cases the 'fit' will not be perfect. However, even if it is, there will still be some parts of reality which are not being scrutinised or even perceived, and no judgements can be made as to whether the theory might explain these or not. An illustration may help to clarify these ideas. In figure 1 the largest, outer circle represents the whole of reality much of which we may never know. Within it a smaller circle represents that part of reality which is perceived by us. Within that a greater or lesser part is encompassed by a theory. The theory represented here does not <u>exactly</u> 'fit' or explain what is perceived.

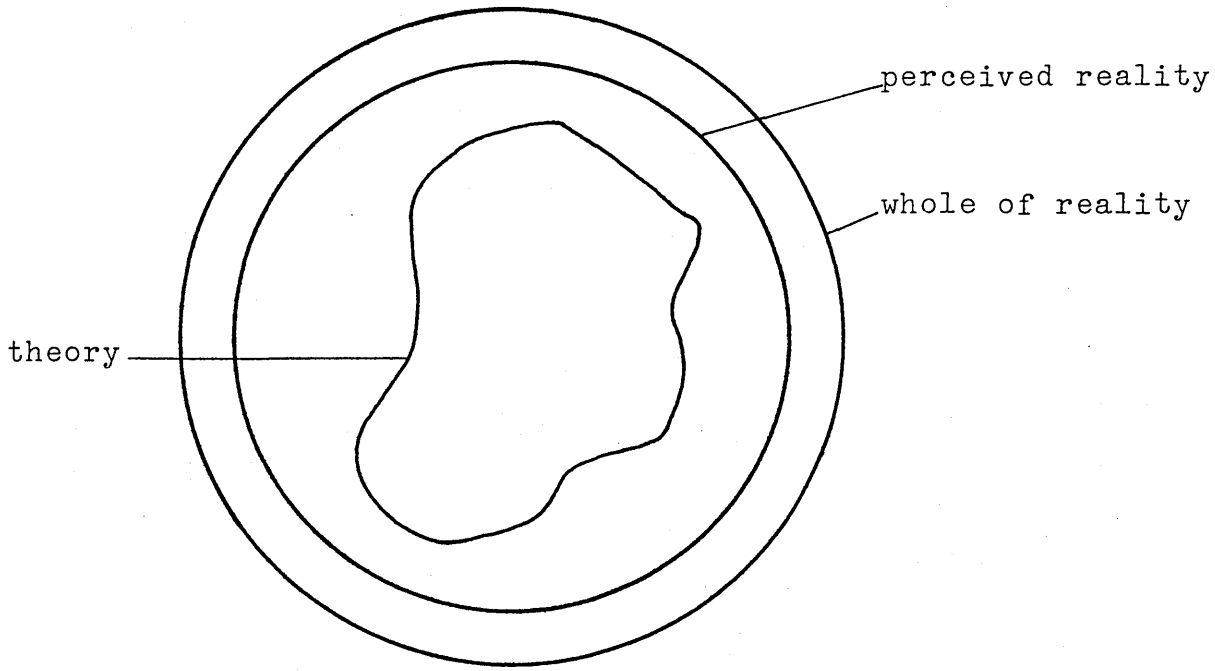


Figure 1 'Reality' and 'theory'

Before discussing ways in which a theory may be developed, something should be said about a dispute common to all kinds of social science, and one which is more specific to nursing.

A great deal has been written in recent years about a 'body of knowledge' in or for nursing - the need for it, the extent to which it is, or can be, unique to nursing, ways in which it might be developed - and much has been said about the relationship between such a body of knowledge and nursing practice on the one hand and nursing research on the other. Within these writings two contrasting approaches to nursing research and nursing theory can be discerned which Riehl and Roy have summarised as the deductive approach in which the theoreticians "select relevant concepts from other bodies of knowledge .... and use these as parameters for looking at specific nursing situations", and the inductive approach in which the theorists "begin with practical nursing experience and

develop concepts from their analysis of this experience rather than borrowing concepts which they feel will fit."(17)

Although these approaches are not mutually exclusive, they are much more than simply alternative routes to the same goal. Nor are they merely contrasting methodologies, although they are often that. Inherent in them are profound differences in perspective which have tended to dominate the social science scene - positivism, which postulates a unity of scientific method for both the social and natural sciences, and phenomenology, which is claimed by some to be the method proper to the social sciences. At first sight these two approaches seem to be diametrically opposed to each other, for positivism, which tends to use quantitative methods, searches for facts and causes of phenomena with little regard for the subjective states of individuals, while phenomenology is concerned with understanding human behaviour from the actor's point of view. It yields descriptive data which enable us to see the world as the subject sees it.

In a paper in which he explores the relationship between nursing theory and nursing research Johnson (18) claims that "nursing theory benefits from a philosophical basis which may be ethical rather than logical in nature", and suggests that speculation should be recognised as a third method of theory construction. He identifies a number of nursing theorists whose work is speculative, at least in part, and argues that this approach is particularly relevant in new disciplines in which neither induction nor deduction has established its superiority as a paradigm for research.

Although an individual social scientist or researcher might tend to be more committed to, or comfortable with, one of these perspectives and approaches rather than

another, each can provide insights which are complemented by insights offered by the others.

This is not the case with the dichotomy which arises from two views of nursing which are, as Stevens (19) suggests, irreconcilable. One of these considers the source of nursing to be in some 'real world' of nursing practice which exists 'out there', while the other considers it to be in a mental construct of an 'ideal world' of nursing practice as it would be if it were done 'correctly'. Commenting on these views Stevens claims that "'nursing' (for most theorists) is a mentally constructed world rather than a real world of nursing practice."

She goes on to say that "the difference between these two perspectives is not always understood by those who try to clarify theory development for nurses". A study of nursing literature suggests that nurses themselves do not always understand this difference, nor do they always make clear which perspective they are using. More will be said about this later. For the moment it should be noted that so profound a difference in perspective is likely to have considerable implications for all aspects of nursing - practice, research, education, management and theory building. For example, it is relevant to the question of whether the deductive or the inductive approach is the more appropriate to nursing; those who are concerned with nursing as it 'ought' to be being more likely perhaps to favour the deductive approach, while those who are concerned with describing, explaining or controlling nursing as it 'really is' might be expected to favour the inductive approach.

How are 'theories' developed?

A number of writers have tried to identify the process by which a theory is developed (20-24). While these accounts differ considerably in the amount of detail which is given and in the terminology which is used, they all suggest a progression through a number of activities which can be summarised into three main stages.

The *first stage* consists of naming, defining and classifying the concepts which are used to describe the phenomena to be studied. This is not simply a description of events or experience, rather it requires a process of conceptualisation which allows the analysis of events and experience in such a way as to lead to understanding and explanation.

The *second stage* establishes the relationships between concepts or categories of concepts. These relationships, (for example cause and effect, inhibition and promotion) give rise to propositions which give the theory its power to explain, predict or prescribe and are therefore crucially important to its development. This stage results in a tentative theory which must be tested before it can be used with any confidence.

The *third stage* uses the tentative theory to derive hypotheses which can be tested experimentally. These studies will either strengthen the credibility of the tentative theory or will lead to its modification and refinement. This process of theory development which is a focal point of discussion throughout this thesis, is represented diagrammatically in figure 2.

Stage 1	CONCEPTUALISATION	naming, defining and classifying concepts
Stage 2	TENTATIVE THEORY	ordering concepts and establishing relationships formulating propositions and tentative theory
Stage 3	THEORY TESTING	deriving and testing of hypotheses modifying and refining the theory

Figure 2 Stages of theory development.

Traditionally much, if not most, research has concentrated on this third stage of verification of theory, and, according to Glaser and Strauss (25), this has resulted in a

> "de-emphasis on the prior step of discovering what concepts and hypotheses are relevant for the area that one wishes to research"

These authors suggest that rather than selecting a problem area in order to test hypotheses derived from predetermined theory, the problem area itself should be used to develop a conceptual framework for understanding and explaining it. It is this approach in which data are used for deriving theory rather than for testing it which they called 'the discovery of grounded theory'.

Glaser and Strauss were not the only, nor even the first, writers to advocate this method, but they have attempted to describe their method in more detail. In

doing so they intended to establish an approach which would be useful for many different kinds of problem, and which could be adapted and developed by those who used it. Unfortunately their own text is somewhat obscure at times, and those who have adopted their approach have tended to use it, or at least to explain it, in a variety of ways. The description which is given here and which is used for this study is derived from a number of writers who have advocated a 'grounded theory' approach, although they might not wish to use that label, as well as from the works of Glaser and Strauss themselves (26-31).

How is 'grounded theory' generated?

The principal method which Glaser and Strauss advocate is that of constant comparison, in which data are collected, analysed, coded into as many categories as possible and compared, datum with datum, incident with incident, until this constant comparison starts to generate theoretical properties of the categories. This means that most concepts and hypotheses not only come from the data but are systematically worked out in relation to them. In approaching a problem or an area of enquiry in this way, without a preconceived theory, the researcher is free to generate or 'plausibly suggest' categories, concepts and hypotheses which are inherent in the evidence, without being constrained to follow a pre-determined line of enquiry, and without developing patterns of thought which prevent him from being able to 'see around' his theory.

The study design is generally formulated with an open approach to the problem being investigated. That is to say, there are no prearranged instruments or procedures, these develop out of the research as it progresses. Initial decisions, for example, about data collection, are based on the general problem area or on a general perspective. Further collection of data cannot be planned in advance of the emerging theory, rather, decisions about what data to collect next and where to find them will emerge from the data themselves. In short, the whole process of data collection is controlled by the emerging theory.

In general, this type of investigation begins with a preliminary period of identifying the problem area and mapping out the background from which the framework for the study evolves. During the *first phase* data are gathered and coded into as many categories as possible

as the researcher attempts to find order in the events observed and tries out 'hunches' to see how they fit.

During the *second phase* attention is directed more specifically to such aspects of the field as events and persons, and the relationships between them, which have begun to emerge as significant categories.

The *third phase* consists of careful scrutiny of the evidence to pinpoint relevant propositions and to determine what further evidence might be required. This phase will often require a return to the field as gaps in existing evidence are identified, or previously unnoticed concepts and categories are recognised. The process is summarised diagrammatically in figure 3.

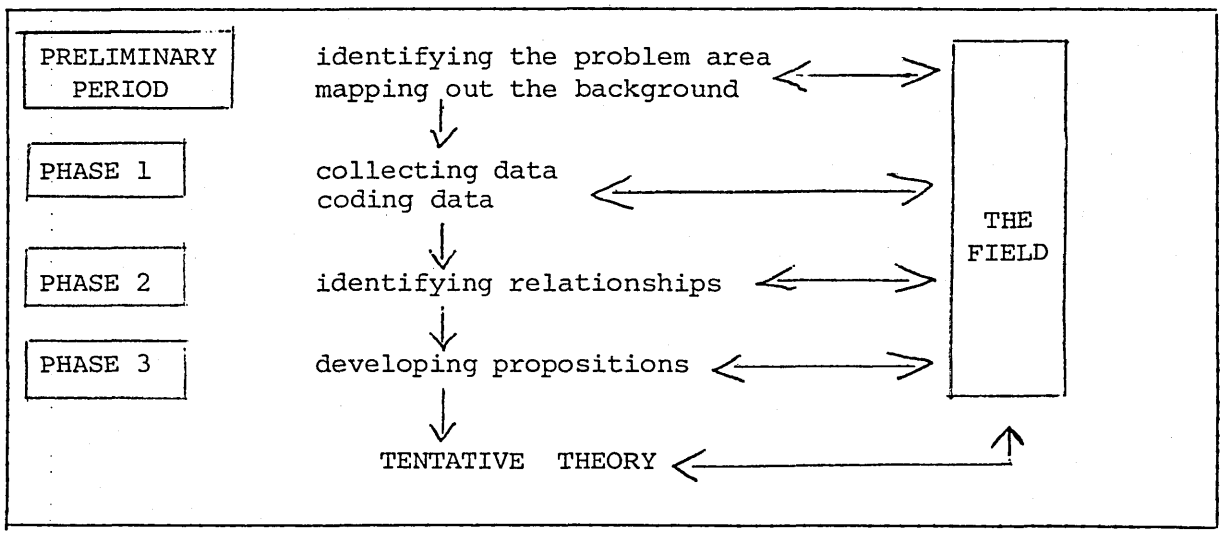


Figure 3 Generation of grounded theory.

Whereas the kind of data required during the third phase is determined by the emerging theory, fieldwork observations in the first phase are guided by general ideas concerning the problem and by previous training and experience of the researcher. However, one does not just go out and gather data and see what they tell us. It is simply not possible to see and record everything that happens;

inevitably some things will not be noticed and some simultaneous events will not be perceived. What is observed will depend on some implicitly held understanding of the situation which in turn is derived from one's own perspective on the specific situation, the broader context and life in general. Whether or not it is possible to recognise and make explicit all of these biases, it is certainly important to recognise that they exist and that even the most open of research designs can never be truly theory free. (32,33,34)

It will be seen from the above description that the grounded theory approach has the appeal of flexibility in that the emerging conceptual categories direct the future data collection, and unforseen lines of enquiry can be pursued in a way which is not possible with more rigid research designs. It has to be stressed, however, that this approach should not be thought of as "a license to generate theory from any source - happenstance, fantasy, dreamlife, common sense or conjecture - and then dress it up as a bit of logical deduction." (35) but as a systematic process which is grounded in the data themselves. Nevertheless, since each step emerges from the one before it, it is difficult to identify beforehand which groups will be used for data collection or what will be the precise timescale. This means that the researcher must learn to live with a high degree of uncertainty.

This approach makes it possible to explore a substantive area of inquiry by exposing and making explicit the conceptual framework inherent in the data and then to examine the existing literature for concepts and for theoretical linkages which relate to the field observations, rather than to look for data which will be relevant to a pre-determined theory. It is therefore suitable for

discovering concepts and propositions which are relevant in areas or to problems which have been the subject of little previous study. In using it to study clinical teaching I have tried to make explicit the process which is outlined above, but inevitably all written accounts suggest a more orderly step by step progression than was actually followed. In practice, the various phases are not always clearly separated and, while this is in part a feature of any research, it is particularly marked in this approach, and is, indeed, one of its strengths. In the pages that follow I have tried to show how the approach 'worked' in practice.

Starting from the general problems of rapid turnover and considerable expressed dissatisfaction amongst clinical teachers, formal and informal discussions were held with practising clinical teachers, their employers and those who are responsible for formulating clinical teaching policy, and recent relevant nursing research was reviewed. This resulted in the identification of a number of specific problems which might be expected to contribute to the more general problems.

This led to more structured interviews with clinical teachers and the use of a questionnaire designed to explore some of these specific problems, and included staff with whom clinical teachers are closely associated. These in turn prompted an extensive library study to gather data relating to the way in which clinical teaching was originally conceived, organised and implemented, and an observational study of clinical teachers to identify current patterns of clinical teaching combined with further interviews and questionnaires.

At each stage it was possible to identify questions and problems which could themselves have provided the focus for a conventional study but which had simply to be noted as possible future concerns. It was also possible at each stage to refine and define the central issues and to identify relevant propositions as they emerged from the data. Although a major part of this thesis is concerned with testing these propositions, the exploratory work out of which they developed is an integral part of the study. Inevitably, a number of false trails were started on, although some of these were only 'false' in the context of the present study.

Figure 4 sets out the empirical and conceptual progression of the study alongside the phases of theory development as they were illustrated in figure 3.

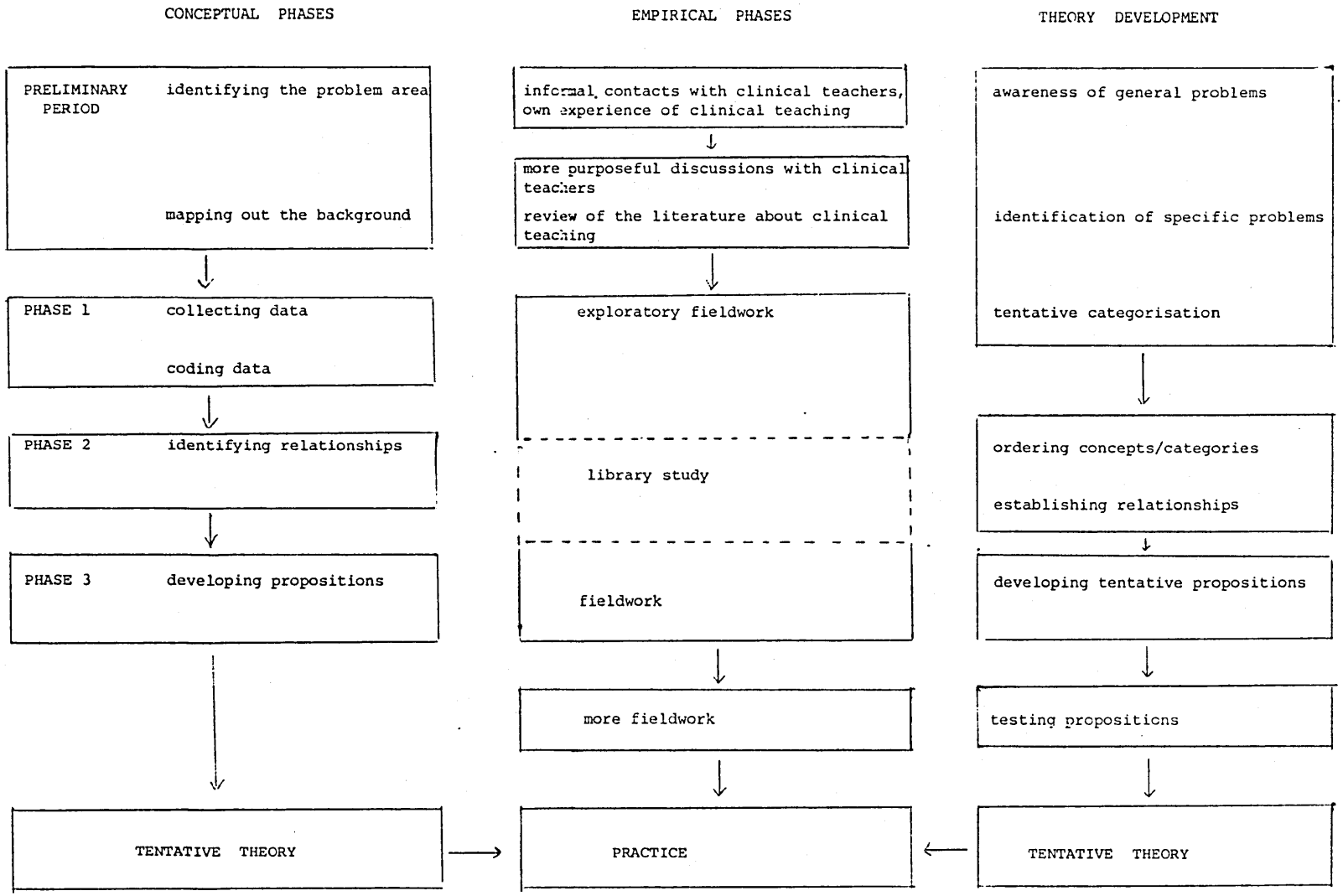


Figure 4 Empirical and conceptual stages of the study.

References for chapter one

1. Treece E.W., Treece, J.W. (1973) Elements of research in nursing. C.V. Mosby Co. St. Louis. p 241

2. Batey M.V. (1977) Conceptualization: knowledge and logic guiding empirical research. Nursing Research 26:5 (Sept-Oct) pp 324-329

3. Fox D.J. (1976) Fundamentals of Research in Nursing. Appleton-Century-Crofts. New York.

4. Stevens B.J. (1979) Nursing Theory: analysis, application, evaluation. Little, Brown & Co. Boston.

5. Gouldner A.W. (1956) Explorations in Applied Social Science. Social Problems 3 (Jan.) pp 169-181

6. Batey M.V. (1971) Conceptualizing the Research Process. Nursing Research 20:4 (July-Aug) pp 296-301

7. Wald F.S., Leonard R.C. (1964) Towards Development of Nursing Practice Theory. Nursing Research 13:4 (July-Aug) pp 309-313

8. Dickoff J., James P., Semradek J. (1975) 8-4 Research Part 1: A stance for nursing research - tenacity or enquiry. Nursing Research 24:2 (March-April) pp 84-88

9. Schlotfeldt R. (1975) The need for a conceptual framework. in Verhonick P. (Ed) Nursing Research Little, Brown & Co. Boston. pp 1-24

10. Donaldson S.K., Crowley D.M. (1978) The Discipline of Nursing. Nursing Outlook 26 (Feb) pp 113-120.

11. Wald F.S., Leonard R.C. (1964) *op. cit.* p 310

12. Glaser B., Strauss A. (1968) The Discovery of Grounded Theory. Weidenfeld & Nicolson. London.

13. Melia K. (1981) Student Nurses' Accounts of their Work and Training: a qualitative analysis. Unpublished PhD Thesis. University of Edinburgh..

14. Chapman C.M. (1972) Clarify the Concepts. Nursing Times 68:5 (22nd June) pp 775-6

15. Dickoff J., James P. (1968) A Theory of Theories: a position paper. Nursing Research 17:3 (May-June) pp 197-203

16. Grypdonck M.H. (1980) Theory and Research in a Practice Discipline: the case of nursing. Unpublished PhD Thesis. University of Manchester.

17. Riehl J.P., Roy C., (1980) Conceptual Models for Nursing Practice. Appleton-Century-Crofts. New York.

18. Johnson M. (1983) Some Aspects of the Relation between Theory and Research in Nursing. Journal of Advanced Nursing 8.1 (Jan-Feb) pp 21-28

19. Stevens B.J. (1979) *op. cit.* pp 6-7

20. Wald F.S., Leonard R.C. (1964) *op. cit.*

21. Glaser B., Strauss A. (1968) *op. cit.*

22. Jacox A. (1974) Theory Construction in Nursing: an overview. Nursing Research 23:1 (Jan-Feb) pp 4-13

23. King I.M. (1975) A Process for Developing Concepts for Nursing through Research. in Verhonick P. (Ed) Nursing Research Little, Brown & Co. Boston.

24. Dickoff J., James P. (1975) Theory Development in Nursing. in Verhonick P. (Ed) Nursing Research Little, Brown & Co. Boston.

25. Glaser B., Strauss A. (1968) *op. cit.*

26. Becker H., Greer B., Hughes E.C., Strauss A.L. (1961) Boys in White. University of Chicago Press. Chicago.

27. Glaser B. (1965) The Constant Comparative Method of Qualitative Analysis. Social Problems 12 pp 436-445.

28. Glaser B., Strauss A. (1965) Awareness of Dying. Aldine. United States.

29. Lofland J. (1971) Analyzing Social Settings: a guide to qualitative observation and analysis. Wadsworth Publishing Co. United States.

30. Glaser B. (1978) Theoretical Sensitivity Sociology Press. California.

31. Melia K. (1981) *op. cit.*

32. Bechhoffer F. (1974) Current Approaches to Empirical Research: some central ideas. In Rex J. (Ed) Approaches to Sociology Routledge, Kegan, Paul. London.

33. Gold R.L. (1958) Roles in Sociological Field Observation. Social Forces 36:3 pp 217-223

34. Schwartz M.S., Schwartz C.G. (1968) Problems in Participant Observation. in McCall G.S., Simmons S.L. (Eds) Issues in Participant Observation Addison Wesley Publishing Co. Massachussets. pp 89-105

35. Glaser B., Strauss A. (1968) *op.cit.* pp 5-6

PART ONE

CLINICAL TEACHING

CHAPTER TWO

CLINICAL TEACHING - A CASE FOR ENQUIRY

Initial Questions

The passing of the Nurses, Midwives and Health Visitors Act, 1979, confirmed that new statutory bodies would in due course bring together the responsibilities and functions of the various existing ones, thus making possible the establishment of a common policy in the United Kingdom in relation to the preparation of teachers of nursing. This has brought into sharp focus the uncertainty which has surrounded the future of the clinical teacher, for, while in England and Wales the General Nursing Council was in favour of having one kind of teacher, who would combine college-based and ward-based teaching, the policy of the General Nursing Council for Scotland was to continue to have two - the nurse teacher (tutor) and the clinical nurse teacher.

The Whitley Council handbook defines a tutor as

> "a registered nurse tutor or a midwifery tutor employed in a teaching division, area or unit"

and a clinical teacher as

> "a Registered Nurse who is wholly employed on the practical instruction of Student and, where appropriate, Pupil nurses in wards and departments to supplement the practical instruction given by the staff of those wards and departments." (1)

Under both Councils these two kinds of teacher have, until now, been prepared in different ways by different courses, and there is an assumption that while the clinical teacher will teach mainly, or only, in the wards, the tutor's main responsibility will be towards teaching in the classroom. For many years, and especially in England and Wales, there have been discussions about

merging the clinical and the classroom functions and producing one teacher who would operate in either sphere. The need for a 'conversion' course for clinical teachers to allow them to teach in the classroom, should such a policy be implemented, has been noted, but, so far, in spite of the differences in their preparation, little has been said about a similar 'conversion' course to allow tutors to teach in clinical areas.* In Scotland, too, there has been uncertainty about the respective roles of the tutor and the clinical teacher and this has been expressed at local level by claims that tutors, too, teach in the wards and should not be confined solely to the classroom duties, and that clinical teachers need to be 'involved' in the whole work of the college.

In 1976 a working party was convened by the General Nursing Council for Scotland to consider the relationship between the tutor and the clinical teacher and the kind of preparation which would be appropriate for each. The ensuing report, which dealt only with their preparation and not with the relationship between them once they were practising, recommended that the two qualifications should be seen as stages in a serial teaching qualification.(2) Since then the Council's policy has been to encourage prospective nurse tutors to obtain a clinical teaching qualification prior to applying for one of the nurse teachers' courses. This has meant that the majority of the 50% or so of clinical teachers in Scotland who leave within two to three years of qualifying do so to attend a nurse tutor's course. However, such evidence as there is suggests that the turnover rate is much the same now

*One reason for this may be that tutors' courses are assumed to include ward teaching.

No information has been sought on the truth of this assumption but in Scotland there have been efforts to avoid duplication of material in the two kinds of courses, particularly since 1976.

as it was a decade, or even two decades ago, and that the Council's policy has changed the destination of those who leave rather than having increased the turnover rate.

In spite of the high rate of attrition, the numbers of clinical teachers in post have increased steadily over the thirty years since clinical teaching began to emerge as a separate branch of nurse teaching, and it is now fairly well established in most training schools and colleges of nursing, while the number of courses preparing clinical teachers has also increased steadily since 1958.(3)

I had not been the course leader of such a preparatory course for very long when I realised that the actual work which a clinical teacher does and the way in which it is organised vary quite considerably from one college of nursing and midwifery to another, and even from one ward to another, and that considerable frustration and dissatisfaction is expressed about clinical teaching, even by those who stay in post for longer than average periods of time. This dissatisfaction is expressed in a variety of ways, but often takes the form of complaints that:

- tutors do not consider clinical teachers to be a part of the college of nursing, yet, at the same time, do expect them to contribute to its work;

- this suggests that the clinical teacher's work in the wards is not as important as the tutor's work in the college;

- ward staff do not understand what clinical teachers are trying to do and impede their work by preventing them having satisfactory access to learners;

- clinical teachers can neither do what they are 'supposed to do' nor what they think they 'ought to be doing'.

These are not new problems. Personal experience as a clinical teacher in the late nineteen sixties and some of the research in the following decade confirm that these dissatisfactions are fairly widespread.

Whereas much of the older research which was concerned with aspects of the preparation of the nurse was directed towards teachers and learners in the school of nursing, more recent studies have addressed the problems of teaching and learning during periods of clinical experience when the learner is working in wards as part of the workforce. Although clinical teaching is often mentioned or included in these studies there has been little research dealing directly with clinical teachers or with their relationship to others who teach nurses, whether tutors or ward staff.

Many writers have identified a conflict between 'education' and 'service' in nursing and have often attributed it to the separation of the college and its staff from the 'real world' as it is found in the wards. For example Dodd (4) commenting on earlier work by Dutton (5), says -

> "Firstly the problem is due in part to the fact that ward sisters view the real nursing role as clinical, practical, patient oriented and at the centre of things. The image of the tutor's role is theoretical, remote and at the periphery of things.
>
> A second point of interest emerging from the study is the progressive reification of the tutor's function coupled with its increasing irrelevancy to ongoing nursing, which Dutton suggests may owe something to the non-cooperative attitude towards tutors entertained by both ward sisters and administrators. .....

> A third point of interest is that the tutor is seen as isolated and alone. The isolation is seen in part as isolation from patients, in part as isolation from the source of high regard, viz, the doctors."

While Dodd was concerned with broader issues than the conflict between service and education, her work did confirm what many suspected, that to the learners the school is where they learn to pass examinations and the wards are where they learn to be nurses. Presumably this dichotomy would not be serious if what was learnt in these two places were compatible, but that this is not always so was later demonstrated by Bendall (6). In a study carried out in twenty schools of nursing she asked learners to write down the action they would take in a given situation. Then by watching these learners at work she showed that, in most cases, what they said they would do was not the same as what they actually did, so confirming that there is often one way of doing things 'for the school' and another way for the wards.

Dodd's study was concerned with the way in which learners perceive themselves, their work and their life in the hospital. In a short section in which she discusses the way in which her respondents saw the clinical teacher's role she says

> "Trainees voiced an overwhelming desire to greatly increase the number of clinical instructors. Few trainees had had actual experience of being taught by one, so the responses indicated an inter-trainee communication pattern highly favourable to the clinical instructor."(7)

She goes on to discuss comments from her respondents which suggest that they consider the clinical teacher to be in an anomalous position *vis à vis* the tutors and the ward sisters -

> "Clinical instructors were seen as having no authority except what they derived from either the tutors on the one hand or the sister on the other. ..... In order to survive, the instructor had to carefully avoid any conflict with the ward sister, avoid any action which might suggest 'shared authority' in the clinical area."(8)

In other words, Dodd is suggesting that the background against which clinical teaching must be studied is one of disjunction between the college and the wards and that the authority which a clinical teacher has, or does not have, in the clinical area may be a key factor in determining the perception which learners have of clinical teaching.

Another study which throws some light on clinical teaching is a survey of nurse teachers who were registered as teachers with the General Nursing Council for England and Wales.(9) Its aims were to discover the general characteristics of this group, to determine where they were working at the time and to elicit their opinions about the satisfactions and dissatisfactions of their jobs. Although the report appears to include both tutors and clinical teachers, it does not differentiate between the two grades, nor are all of the data analysed separately. This means that it is not always clear whether it is referring to all teachers of nurses or only to tutors at any given time.

The report is in two parts, and it is the second part dealing with the analysis of the open ended questions which is the more relevant here. Much of this material deals with the satisfactions and dissatisfactions of the job and suggests that those working as clinical teachers and Principal Nursing Officers (Education) were marginally more satisfied while those working as Senior Nursing Officers and tutors were marginally less satisfied.

In an attempt to identify the reasons for these satisfactions or dissatisfactions respondents were asked to indicate the three most satisfying and the three most dissatisfying aspects of their jobs. These were termed 'satisfiers' and 'dissatisfiers' respectively. For all kinds of teachers by far the most important satisfier was found to be teaching itself, and for the clinical teachers the next most important was their contact with patients. With respect to clinical teachers' relationships with colleagues, this group differed markedly from the tutors in that they rated their relationships with others as being more satisfying than their relationships with other teachers. Since clinical teachers are supposed to work in the wards this may not be surprising but they are controlled and employed by the college of nursing and often spend a considerable proportion of their time there and, as in this survey, they are usually classed as teachers of nurses by other people as if their orientation and opinion would be comparable with those of tutors. In the light of these findings that assumption needs to be questioned.

None of the dissatisfiers elicited anything like the same amount of agreement as did the satisfiers 'teaching' and 'patient contact', but the three which headed the list were 'inadequate recognition of the clinical teacher's job', 'the education/service conflict' and 'inadequate definition of responsibility'.

When respondents were asked what might be done to improve matters the most common suggestions were 'recognition of the job done by clinical teachers', 'better control of the students' education' and 'more liaison with ward staff'.

In its comment on these results the report has this to say -

> "Interestingly for a group intended to function in the ward situation, one frequently comes across such responses as 'too much time in the school, so no time for the wards', 'more liaison with ward staff needed', 'clinical teachers should be more ward based'. They seem to feel unsupported by their tutor colleagues in that their satisfactory relationships are found elsewhere .... and .... their problems seem to be unrecognised by other teachers ..." (10)

These comments lend weight to the report's claim that when there is a shortage of tutors the clinical teachers are likely to be withdrawn from the wards to work in the college but it should not be too readily assumed that the plea for a more definite ward base for clinical teachers is a result only of the amount of time which they spend in the college. Clearly the extent to which clinical teachers identify with the college of nursing or the wards is one which requires further investigation.

The comment quoted above also suggests that clinical teachers were intended to function primarily in the ward. The next four studies under consideration here are concerned with the learning experiences of nurse learners while they are in the wards.

The first of these, by Ogier (11), deals with 'the effect of ward sisters' management styles upon nurse learners', while the next two, Orton (12) and Fretwell (13), consider aspects of the ward as an environment in which learning is expected to take place. The fourth study, Alexander (14), is rather different in emphasis, since it describes an experiment designed to increase the integration of 'theory' with practice.

Ogier was intrigued by the perceptions which learners have of ward sisters and consequently of their wards as being 'good' or 'not so good' places in which to work. Her study is directed towards identifying differences in the

leadership styles and verbal interactions of ward sisters and does not deal with clinical teaching specifically at all. Nevertheless, it does shed some light on the expectations which trained staff and learners have of the time which learners spend in the wards.

In trying to identify the approach to learning in the wards of these two groups Ogier divided learning opportunities into five categories - know how to do, know about, ward climate, learning accessories, and other - and tried to establish the importance which respondents put on each of these . Her results show that trained staff are primarily concerned that learners should know 'how to do', whereas learners are equally concerned to 'know about' what they are doing. This has obvious implications for the content of clinical teaching. Perhaps even more significant, however, is the finding that when asked how more support could be given to them in the wards, nearly a quarter of the learners mentioned the need for more clinical teaching. Again, one must not make assumptions too readily. The study says nothing about the amount of clinical teaching actually provided, it merely records the opinion of learners that they would like to have more. This corresponds to Dodd's findings that learners value their contacts with clinical teachers. However, without knowing how much clinical teaching was given we cannot know whether this represents a judgement based on first hand experience, or whether it is a second hand opinion, as is the case with Dodd's respondents, few of whom had actually worked with a clinical teacher (see page 28)

That the 'learning climate' of a ward exists as a measureable reality for learners and that there is considerable agreement amongst them as to those wards which have favourable or unfavourable climates, was demonstrated by Orton. Like Dodd, she identifies the

relationship between college staff and ward staff as a potential source of conflict for the learner - where tutors and ward sisters exhibit differing attitudes and belief (*sic*) learners are likely to suffer role conflict because they occupy separate yet overlapping spheres. (15) Although this study is not concerned with clinical teachers, it is not unreasonable to assume that they are similarly affected.

Orton's main concern was to identify the significant characteristics of what she termed 'high student oriented wards' and 'low student oriented wards'. Her study showed that the ward sister is the person who determines the learning climate according to whether she regards the nurse-in-training as a learner or a worker.

Fretwell(16) confirms this in her study of the characteristics of the 'good' teaching ward. She comments that the ideal learning environment is one "which has moved away from the traditional model of nursing" and stresses that it is the ward sister's orientation which determines the quality of teaching and learning in the ward and the rate at which the traditional model can be replaced by one which is more suited to teaching. While her respondents seem to have appreciated the teaching done by clinical teachers, it is clear from the responses which she quotes that they, the clinical teachers, are not in the wards often enough to be regarded as the dominant teachers. Whether clinical teachers have any influence in determining the learning climate of the ward is a question which neither Orton nor Fretwell considers, but, since both regard them as 'external agents' who only visit the wards occasionally, it must be assumed that the clinical teachers' influence on the ward climate was not sufficient to distract their attention from the ward sister as the key person.

As already indicated, Alexander was concerned about the 'gap' between theory and practice. She designed an experiment to explore ways of increasing their integration. In the course of her study she sought information from learners and from the various groups of staff in their role set (that is ward staff, tutors and clinical teachers) about the kind and amount of ward teaching which students received while working in general medical and surgical wards, and about their opinions of the ward teaching functions of the various grades of staff. In doing this she gathered a considerable amount of information which is directly relevant to the work of the clinical teacher. The findings from this part of her study can be considered under three headings -

people who are seen to be the most important teachers in the wards,

the functions of the clinical teacher,

other staff's opinions of the clinical teacher's functions.

Although the majority of ward sisters said that they taught often or fairly often in their own wards, the students were in no doubt that it was the staff nurses who were their most important teachers and that the amount of teaching done by other students was almost as great as that done by the staff nurses. This was true whether the teaching took the form of supervision and practical demonstration or of short teaching and tutorial sessions.

> "Other student nurses contributed almost as much to the former type of ward teaching as did the staff nurses, and considerably more than either the ward sister or the clinical teacher. ..... When the giving of tutorials was considered, the students in this sample considered the contribution of fellow student nurses to be less than that of the staff nurses, but very slightly more than that of the ward sister and the clinical teacher."(17)

These findings are illustrated by tables which show the frequency with which each grade of staff undertook each type of teaching. The study was carried out in five colleges of nursing in Scotland and it is apparent from these tables that there is considerable variation between them in the frequency with which clinical teachers contribute to these kinds of teaching. There is also considerable variation in the deployment of clinical teachers in these colleges, from one who spent all of his time in the college, to some whose college commitment took up 10% of their time or less.

Clearly the deployment of clinical teachers is linked to the frequency with which they contribute to teaching in the ward, but much more needs to be known about the way in which clinical teaching is organised in different colleges and hospitals before any firm conclusions can be drawn from these findings. All grades of staff were asked who ought to be doing the ward teaching and in which ways the teaching functions of the clinical teacher differ from those of tutors and ward sisters. The answers to these questions show considerable differences of opinion, both within each grade of staff and between the grades. It is interesting that there was more agreement between clinical teachers and ward staff as to their respective functions than there was between clinical teachers and tutors about theirs, and this perhaps suggests that the clinical teachers' complaint about 'inadequate recognition of the clinical teachers' job' which was noted in the 1975 survey by the General Nursing Council for England and Wales (18) applies particularly to tutors.

Although the studies described above were not specifically concerned with the work of the clinical teacher they do confirm the impressions gained from my contacts with the General Nursing Council for Scotland, tutors

and with clinical teachers, namely that the frustration and dissatisfaction experienced by clinical teachers have their roots in the ways in which clinical teaching is perceived by various groups of staff, and in the way in which it is organised and implemented. These impressions are also supported by personal experience of clinical teaching during the nineteen sixties. (see page 27)

Thus, this study was prompted by personal experience, professional contacts and an awareness of questions raised by the, admittedly, limited research relevant to this aspect of professional practice.

Clarifying the Problem

In the first part of this chapter a number of complaints and difficulties which clinical teachers express when they are encouraged to talk about their work have been identified and discussed. These complaints and difficulties are listed now as the kind of random and unordered raw data which can be expected as a result of going into the field and starting to ask questions:

clinical teachers were intended to work in the wards but they are not sufficiently ward based and spend too much time in the college

learners are highly favourable towards, and would like more, clinical teaching

learners and ward staff have different perceptions of what learners need and want to be taught

the way in which clinical teachers are deployed and clinical teaching is organised differs from college to college, and even from ward to ward

ward sisters impede clinical teachers by preventing them from having adequate access to learners

tutors expect clinical teachers to do college work

clinical teachers can neither do what they are 'supposed' to do not what they 'should' be doing

there is inadequate differentiation between the work of the tutor and the clinical teacher

there is more agreement between clinical teachers and ward sisters about their respective functions than there is between clinical teachers and tutors

clinical teachers have different opinions and different orientation from those of tutors

clinical teachers do not receive sufficient support from tutors

tutors seem to imply that clinical teaching is not as important as 'tutoring' and that clinical teachers do not really belong to the college

there is inadequate recognition of the clinical teacher

learners see the college as the place where they learn to pass examinations and the wards as the places where they learn to be nurses

there is conflict between service and education, and the clinical teacher is caught in the middle of it

ward staff do not understand what the clinical teacher is trying to do

the quality of ward teaching is determined by the ward sister rather than by the clinical teacher who is considered to be an outside agent

learners do not see the clinical teacher as having any authority in the clinical area

there is inadequate definition of the clinical teachers' responsibility

The fact that questions about clinical teaching result in such answers shows that the respondents thought about the subject in very complex ways. If the answers had been based on clear, straightforward conceptualisations of what clinical teaching is about, they, too, would have been clear and straightforward.

Each of the items listed above gives rise to a number of questions. The next stage is to analyse the data and the emerging questions and attempt to order them into possible underlying categories. In appendix 1 a full list of the emerging questions is given with indications of how possible categories were developed. When this was done, the categories identified in this way were then grouped into five more major categories relating to different aspects of the main problem area of clinical teaching. The following is the result of categorising the raw data in this way.

1. the organisation of clinical teaching -
   definition of the job
   content of the job
   deployment of clinical teachers

2. the implementation of clinical teaching -
   content of the teaching
   amount of time given to each learner
   relations with the ward sister

3. the expectations about clinical teaching -
   held by tutors, ward staff, learners and clinical teachers expressed as an 'ideal' of clinical teaching

4. the alleged conflict between the wards and the college, and the clinical teacher's orientation towards one or the other

5. the attitudes of, and towards, clinical teachers -
   the influence of the clinical teacher on the learners
   the influence of the clinical teacher on ward teaching
   the clinical teacher's lack of responsibility in the clinical area
   the clinical teacher's sense of being misunderstood and undervalued

These categories are not mutually exclusive, for some of the items presented as raw data could appropriately be included in more than one, nor are they necessarily of equal importance or of equal magnitude. Although, as is indicated, it is possible to identify some subdivisions within the major categories (or 'properties of categories', to use Glaser and Strauss' terminology(18)), at this stage these were only tentative, giving pointers to the kind of data which might be required.

In order to explore the subject further, a small exploratory study was planned, which included clinical teachers, ward staff, tutors and learners and which made use of both interviews and a modified postal questionnaire. This study was designed to test whether the categorisations outlined above came close to the undisclosed conceptualisations of clinical teachers who provided the raw data

for it. If these categorisations are reasonable, then the same kind of data, albeit more specific and more detailed, should be obtained from a more structured data collection. On the basis of the analysis described above, therefore, a short questionnaire was designed for each of the four groups of staff. These questionnaires consisted of two parts: firstly, a number of statements relating to opinions about clinical teaching and clinical teachers and to perceptions of what clinical teachers do, with which respondents were asked to agree or disagree; secondly, a number of open questions which asked respondents to give their own opinion of what clinical teachers should or should not be doing. In addition, learners were asked to indicate how many clinical teachers had worked with them to date, how often they saw a clinical teacher and how much time, on average, clinical teachers spent with them. (see appendix 2)

Initially the closed statements of the first part were given to colleagues and their comments invited. They were then revised and tested by appropriate groups of staff (*i.e.* the clinical teacher, tutor and trained staff questionnaires were tested by midwifery staff in these posts and the learners' questionnaire was tried out by first year undergraduate nursing students who had just completed their first clinical placements). At each stage of these trials discussion led to the identification of ambiguities in the statements, to new questions, and to new aspects of the subject being considered, so that the exploratory questionnaires which were finally used reflected both my own understanding of the problem at the time and the concerns of the various groups with which I had discussed it.

The small exploratory study was carried out in a college of nursing and its associated hospitals which were within reasonable travelling distance. The project was discussed with the principal tutor and the district nursing officer who both gave it their support, a letter was sent to each of the college's three clinical teachers describing the study and inviting them to participate. At the same time letters were sent to the divisional nursing officers describing the study and asking permission to distribute the questionnaires to their staff. All staff were told that the information gathered would be confidential and that the results of the data collection would not be discussed with senior staff. (appendix 2)

An explanatory letter and an addressed envelope were attached to each questionnaire which respondents were asked to complete and return, via the internal mail, by the end of the month, thus allowing three weeks for their distribution and collection. (appendix 2)

The work of the clinical teachers in the college on which this small exploratory study was based consisted of two parts, namely, 'college' work and teaching in the wards. The term 'college' work may be used in slightly different ways but during this study both the ward staff and the clinical teachers undoubtedly used it to denote the work which took place in the formal training establishment as opposed to the service areas of the hospitals, that is the formal teaching and learning which went on during lectures and study blocks and the administrative and other activities which support the formal curriculum and programmes of study, *e.g.* selection of applicants, examinations, and ordering and maintaining books and equipment. The teaching itself was usually referred to as 'classroom teaching', even though it included practical

work in the demonstration room and such activities as small group discussions and tutorials, while the curriculum was referred to as 'theory'. Almost invariably 'theory' and 'college work' were contrasted, implicitly if not explicitly, with ward teaching and 'practice', and in the comments of the ward staff and learners there was the implication that 'theory' and 'practice', although related, could each exist in isolation. Experience suggests that this way of thinking and speaking, which is part of what has been referred to as the conflict between education and service, is not uncommon amongst nurses, and it forms the background against which this study must be seen.

In all, one hundred and ninety questionnaires were sent out to trained staff, learners, tutors and the three clinical teachers, and one hundred and twenty were returned. It must be stressed that in this early stage of the development of a tentative theory which is grounded in the data, when propositions are still being generated, statistical sampling which is directed towards the testing of hypotheses has no place. This group of respondents was not, therefore, and was not intended to be, a representative sample in a statistical sense, and, although a survey technique was used, no statistically valid conclusions can be drawn from it. What can and has been done is to use Glaser and Strauss' method of constant comparisons to generate categories, questions and tentative hypotheses which are relevant to the problem. By giving each response in the closed, agree/disagree questions a value from +2 to -2, an attempt was made to construct a measure of how favourably or unfavourably learners and trained staff viewed clinical teachers. Although this measure was extremely tentative it appeared to work fairly well. However, as new categories emerged and existing categories were confirmed and elaborated

from the new data, the focus of the study moved away from attitudes towards expectations, and this approach to measuring attitude tendencies was not developed any further.

Although the use of a computer allowed fairly rapid cross tabulation of the closed questions according to whether respondents were students or pupils, their year of training, the grade of trained staff, the kind of hospital in which they were working, and the clinical teacher through whom they had been contacted, these were of much less help than the open questions, and most of them were revised or rejected for later phases of the main enquiry. The open questions from each group of staff were considered separately and from these were identified specific types of activity in which the various groups thought that clinical teachers ought or ought not to be engaged. The activities so identified were not the same for each group, but whether this was because their expectations were actually different, or because they had simply expressed different priorities, it was not always possible to tell from the questionnaires. Nonetheless, there were some clear indications of conflicting expectations, particularly when the data from each group are compared. The focus of the learners and the trained staff was on the clinical teachers' work in the wards.

Learners thought that the clinical teacher should, primarily, respond to their needs and discuss their problems with them. They expected to receive support, correction and explanation from her, and that she would work closely with the ward staff, organising the clinical teaching in conjunction with them. They expected clinical teaching to consist of the supervision and demonstration of nursing procedures, tutorials, group discussions and lectures on all aspects of their ward work, including the

patients' diseases and the psychiatric learners in particular, expected help with their college written work and in preparation for examinations. Whether these were their own preferences or whether they had come to expect it because that was what was being done was not always clear. Most said that they saw a clinical teacher in their present ward once a week or less often and for periods of up to three quarters of an hour. These contacts were seldom if every initiated by the learner. They would have liked more contact with clinical teachers than they were getting and they expected all learners to be given equal attention.

Trained staff thought that the clinical teacher should be part of the ward staff, joining ward rounds and hearing reports, and that she should provide liaison with the college for the ward staff, keeping them informed of new developments in nursing, the needs of learners and what they were being taught. They thought that there should be a planned programme of instruction and would have liked more frequent visits from the clinical teacher, although they stressed that these should be at times which were suitable to the ward staff and should not interrupt ward routine. They, too, expected clinical teaching to be related to ward activities and patients but they were divided as to whether this should be mainly in the form of tutorials or of 'practical teaching'. They did expect clinical teachers to give the learners written work.

In spite of being unanimous in their agreement with the statement that 'clinical teachers should confine themselves to ward teaching', two thirds of the tutors also agreed that 'clinical teachers should contribute to the whole work of the college'. Unfortunately, none of them took the opportunity provided by the open questions to identify the kind of activities which they thought the clinical teachers should be undertaking, the only comments

in this section being that clinical teachers should be doing "practical teaching at the bedside" and not "classroom style tutorials".

In addition to completing the questionnaires, the three clinical teachers and the principal tutor were interviewed. These interviews followed a fairly fixed schedule which was mainly directed to the way in which the clinical teaching was organised and implemented. Although respondents were encouraged to comment freely about any aspect of clinical teaching at the end of the interview, the schedules proved to be too restrictive and inhibiting for both the respondents and the interviewer. (appendix 2)

From what the clinical teachers said during the structured interviews and in the more informal discussions following them, it became clear that they felt ambiguous towards and were unhappy about, 'college work'. Phrases like "you are expected to do all things when necessary and your own work when you have time" or "I didn't really want to be a tutor" or "if we could do one thing or the other" suggest that they experience two problems in this area of their work. In the first place, it is difficult to accomplish both kinds of work, possibly because of the time available - "having to come back to the college is an absolute menace" - or perhaps because of the nature of the work - "having to do both makes it a very heavy week". Secondly, and probably more importantly, since it was mentioned in one form or another much more frequently, college work is not thought to be work that clinical teachers 'should', 'legitimately' be doing. The reference by one of the clinical teachers in a quotation given above, to her 'own work' *i.e.* ward teaching, in contrast to 'all things' *i.e.* college work, perhaps brings this out most clearly, but each of them indicated that they considered that in being expected to do classroom

teaching and other college work they were being misused. The strength of this feeling varied and each clinical teacher professed to enjoy classroom teaching (one has since undertaken a tutor's course). However, it was the combination of the two types of teaching, the fact that college work took them away from the wards and the feeling that this was 'tutor's work', that they complained about. "It's the combination. If we were all doing it that would be ideal." Although the principal tutor said that she thought that the clinical teachers should have some experience of the whole work of the college, she shared their views about classroom teaching. "They do practical work with junior blocks, but it's not my idea of clinical teaching ..... It's expediency, really, ... They should not be used as unqualified tutors" (Both this tutor and the three clinical teachers made an exception of teaching practical nursing to the introductory block on the grounds that this gave the clinical teachers the opportunity to meet and work with new students before they went to their first wards, and therefore was of benefit to their ward teaching).

Data from both parts of the study were analysed and coded using the categories given on page 39 As each item was compared with those already allocated to one or more categories, three things happened. Many more items were found to be appropriate to three of the categories than to the other two. Within these broad groupings a number of sub-sections became apparent. As the material was ordered and considered within this emerging framework two aspects of the subject began to dominate it, namely the range of work which respondents considered to be 'legitimate' for clinical teachers to undertake and the way in which the 'clinical' part of their work was

organised and carried out.

As analysis and coding progressed the major category "expectations about clinical teaching" and the subsection of another "definition of the job" were merged under the heading "way in which the job is conceived/defined" to form a new category. A summary of the new categories on completion of this stage of the analysis is given below.

1. the way in which the job is conceived/defined -
   - variability
   - 'legitimacy'
   - overlap with tutors

2. the organisation of clinical teaching -
   - content - 'college work'
     'teaching at the bedside'
   - deployment - proportion of 'college work'
     allocation of wards - number, speciality, geography
     span of duty
   - preparation of the clinical teacher

3. the implementation of clinical teaching -
   - content of ward teaching
   - pattern of ward teaching - method
     choice of ward
     choice of learner
     choice of topic
   - relations with ward staff
   - support given to clinical teacher
   - monitoring/control of clinical teacher/teaching
   - sources of grievance/conflict

4. the alleged education-service conflict

5. the attitudes of, and towards, clinical teachers -
   - of staff and learners to clinical teachers/ teaching
   - orientation of the clinical teacher
   - clinical teacher's sense of being misunderstood and undervalued

It is important that at each stage of the process the researcher takes time to "think round" the data and to ask, "Am I still asking the most relevant and pertinent questions?", and, "How does this new information relate to what has gone before?". This kind of informed and constructive thinking is just as much a part of the data as the results of interviews and questionnaires and is closely related to the speculation which Johnson (19) refers to as a source of theory. In this case it was the links which were being made between the comments of present clinical teachers and my own past experience as a clinical teacher which helped to turn my attention towards the expectations which clinical teachers and others had of the job.

It is clear from what respondents said that there were a number of actual or potential differences or even conflicts in the expectations which these various groups had of clinical teaching and in the way in which the clinical teachers actually worked, or were said to work. The fact that the clinical teacher, who is not a member of the ward staff, is expected to teach learners in the wards while they are on duty as members of the workforce in itself suggests potential difficulties and problems. If, as this study suggests, there are considerable variations in the ways in which she is expected to do this, those difficulties may well be exacerbated. At least in this college, the number and geographical spread of each clinical teacher's allocation and the requirements of her college duties suggest that she will be able to spend comparatively little time in any one ward in the course of a week.

In the light of this and of the analysis summarised above it was possible to reassess the direction which this

enquiry should take, and to refocus it by posing two more questions:

> is there any generally agreed prescription of what constitutes the work of the clinical teacher?
> *i.e.* of the boundaries between 'tutoring' and clinical teaching, and of the clinical part of the work?
>
> what do clinical teachers actually do in the wards?

Although these two questions are closely related, the search for answers to them took very different forms. The first led to a 'search for origins' which started by considering a number of clinical teacher job descriptions and went on to an examination of a variety of historical material produced over three decades and dealing with nursing in the United Kingdom as a whole. The second led to an observational study of three clinical teachers working in one Scottish health district.

Inevitably when these studies are reported one has to come before the other, but in fact they were conducted concurrently, although one took longer than the other. Figure 5 illustrates the sequence of the enquiry so far.

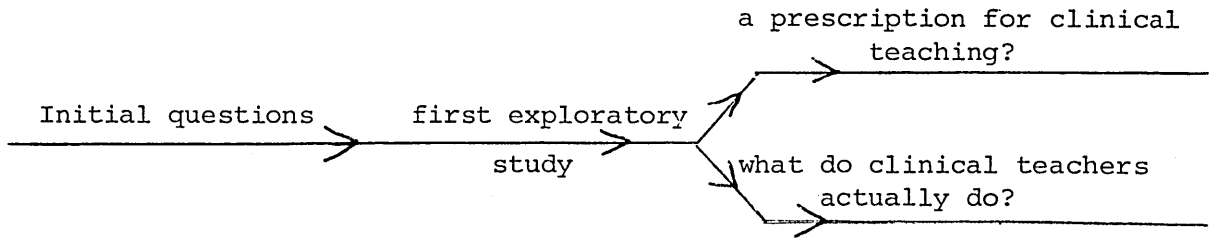


Figure 5 The sequence of the enquiry leading to the historical and observational studies.

References for chapter two

1. Nurses and Midwives Whitley Council (1976) Pay and Conditions of Service Whitley Councils for the Health Services H.M.S.O. London p 10

2. General Nursing Council for Scotland (1979) Report of a working group Unpublished paper

3. Brook E.E. (1977) Hospital Teaching Practice Unpublished paper prepared for Middle Management course.

4. Dodd A.P. (1973) Towards an Understanding of Nursing PhD Thesis University of London pp 53-54

5. Dutton A. (1968) Factors Affecting Recruitment of Nurse Tutors King's Fund London

6. Bendall E. (1975) So You Passed Nurse! Royal College of Nursing London

7. Dodd A.P. (1973) *op. cit.* p 128

8. *Ibid* p 128

9. General Nursing Council (1975) Teachers of Nursing G.N.C. London

10. *Ibid* p 25

11. Ogier M.E. (1979) Study of the Leadership Style and Verbal Interaction of Ward Sisters with Nurse Learners PhD Thesis Burbeck College, University of London

12. Orton H.D. (1979) Ward Learning Climate and Student Nurse Response MPhil Thesis Sheffield City Polytechnic

13. Fretwell J.E. (1978) Socialisation of Nurse Teaching and Learning in Hospital Wards. PhD Thesis. University of Warwick.

14. Alexander M.E. (1980) Nurse Education: an experiment in integration of theory and practice in nursing. PhD Thesis. University of Edinburgh.

15. Orton H.D. (1979) *op.cit.* p 127

16. Fretwell J.E. (1978) *op. cit.*

17. Alexander M.E. (1980) *op. cit.* p 516

18. Glaser B.; Strauss A. (1968) The Discovery of Grounded Theory. Weidenfeld & Nicolson. London.

19. Johnson M. (1983) Some Aspects of the Relation Between Theory and Research in Nursing. Journal of Advanced Nursing. 8 (Jan-Feb) pp 21-28.

PART TWO

'THE ORIGIN OF A SPECIES'

CHAPTER THREE

THE SEARCH FOR ORIGINS

Having arrived at two questions, namely

(a) is there any generally agreed prescription of what constitutes the work of the clinical teacher?

(b) what do clinical teachers actually do in the wards?

it was decided to deal with the second question by going with several clinical teachers to the wards to observe them at work (see Chapter 7). The first question and its corollaries was more difficult to deal with since it seemed to require the identification and examination of formal definitions or descriptions of clinical teaching, and the extent to which clinical teachers and others agreed with them.

Clinical Teacher Job Descriptions

Reference has already been made in chapter two to the Whitley Council definition of a clinical teacher as "a Registered Nurse who is wholly employed on the practical instruction of Student and, where appropriate, Pupil Nurses in wards and departments." (1) but a more detailed description of what this means was required. As part of their selection and employment procedures many colleges of nursing have developed 'job descriptions' setting out the responsibilities and requirements of each post, and a copy of the relevant job description often accompanies a request for a reference. A number of clinical teacher job descriptions had come into my possession in this way and initially these were examined and compared. Three of these job descriptions came from Scottish colleges whose staff later participated in field work during this study, and three came from English schools of nursing which took no part in the study. As indicated above the selection of these particular job descriptions was entirely fortuitous. (appendix 3)

Of the 9 to 22 items presented in each of these job descriptions only four were common to all six:

teaching in the wards
participating in examinations/assessments
keeping records
attending meetings of various kinds.

It may be significant, in view of the complaints and difficulties identified in chapter two (page 37) that classroom teaching is mentioned in only one of the job descriptions, and that it is in the items referring to what was classed as 'college work' on page 41 that there is most variation.

It must be acknowledged that there are differences of opinion about the usefulness of job descriptions. The extent to which it is accepted that an occupational role is moulded by the person who occupies it depends on the nature of the occupation as well as the approach of those responsible for relevant policy. It can be argued that for many jobs it is almost impossible to specify all of the appropriate functions, methods of work and responsibilities. To try to do so might create too narrow and limited a view of a complex job. On the other hand, anything not sufficiently detailed may be scarcely worth the effort. Those who favour job descriptions argue that they force the compiler to think more clearly about the functions of a particular occupational role and that, at the very least, they set boundaries which will go some way towards preventing the person concerned from taking over, or being given, parts of somebody else's job.

Without entering into this controversy, it can be said that the six job descriptions referred to above no doubt reflect these various approaches and that some of their differences are due to this and to the varying

amounts of detail which are given. Nevertheless, whether they are couched in broad general terms or are more detailed, job descriptions provide a particular kind of evidence of the ways in which people think about clinical teaching. It must, therefore, be possible to apply the same kind of analysis of the conceptualisations on which they are based as is applied to other raw data. Even allowing for the differences in specificity, these job descriptions suggest that there are marked differences in the ways in which their compilers have thought about clinical teaching, and in the boundaries within which it is expected that the clinical teacher will work. In particular it is evident that some expect the clinical teacher to take the initiative in planning and organising her teaching in the wards in co-operation with the ward sister and that this is seen as a primary and positive activity, while others suggest that she should be regarded mainly as an extension of the college tutorial staff and should participate in most of the activities of the college. These differences can be summarised, using the categories developed in chapter two and set out on page 47 as:

1.	the way in which the job is conceived/defined the difference in priority given to the various aspects of the job
2.	the organisation of clinical teaching - content - 'college work' 'teaching at the bedside'
3.	the implementation of clinical teaching - relations with ward staff

Although the way in which those in authority conceive a job is an important factor in determining the framework within which it will be performed, there are other factors which may be equally important. One of these is the organisational constraints which will be brought to bear on the work. Features such as the physical layout of

the work places, the equipment which is available, work routines and procedures, and the way in which the job impinges on that of others will all play a part in determining what the job holder sees as being possible and desirable.

The expectations which other people in the workfield have of a job is a second factor in determining the way in which a job will be performed. An organisation is not a collection of isolated individuals performing their allocated tasks, but a social system in which each member interacts with all the other members. There is a sense in which work performance is dependent to some extent on what other people with whom the individual interacts will accept or allow. These other people are tied to the job occupant or role holder by mutual rights and obligations, and they will have their own interpretation of the ways in which these should be discharged. The way in which an occupational role is enacted is, like any other role, mediated to a greater or lesser extent by the responses of those people who form the role set and who exert pressure on the role holder, or actor, in the form of rewards or sanctions to persuade her to act in ways which they find acceptable.

Thirdly, the actor herself will have expectations of the job which will help to determine the way in which it is actually performed.

Role expectations

The fact that people's expectations help to shape an individual's behaviour is well recognised by social scientists and much has been written about the ways in which these expectations arise. For example, Benne and Bennis (2) discuss the forces which determine the nurse's

role and they go on to examine the frustration which is felt by the new recruit who finds that her image of 'real' nursing conflicts with the functions which she must assume in the actual work situation. These authors identify four sources of the image of 'real' nursing - the non-nursing public, the training schools, patients and their families, and doctors. There are parallels here for clinical teaching, for clinical teachers, too, appear to hold an image of 'real' clinical teaching which differs somewhat from their actual work and, perhaps, from what others, including those to whom they are responsible, expect of them. It is possible to make some tentative suggestions as to the source of this image of 'real' clinical teaching; the public image of the teacher, the preparatory courses, and the model of clinical teaching in the medical school (in which a consultant takes a group of medical students on a ward round or seats them round a patient to discuss aspects of that patient's condition with them) might all contribute to the notion of the kind of activities which are appropriate to the clinical teacher.

In addition, there is a tendency for us all to idealise the past and to seek legitimation for our preferred way of doing things in tradition. Phrases such as "when I started nursing" or "in my young days" imply that in the speaker's eyes the old days and ways were better than the present ones and that there has in some way been a deterioration. Even if there is evidence that the past in question was demonstrably poor, this does not appear to affect the tendency to idealise it. Indeed the past which is being invoked may be a myth as in the case of Rousseau's noble savage, yet it can become a potent part of a tradition from which may be derived an 'ideal image'. These 'ideal images' are seen to

indicate how it was in the past, or that this was how the job was conceived when it was first established. Given that we tend to idealise the past in this way and allow these idealisations to influence our view of the present, it is suggested that the way in which clinical teaching was originally conceived, organised and implemented may have been based on, or have become, what can be described as an 'ideal model'.

In view of these considerations it was decided not to undertake a more systematic examination and comparison of job descriptions at this stage but to try to discover whether this ideal model was ever a reality and the extent to which it has contributed to the present by examining the way in which clinical teaching emerged as a separate occupation. Two questions arise on which such an examination may focus -

> does the development of clinical teaching show a parallel development of an ideal model of clinical teaching?
>
> was that ideal model of clinical teaching ever a reality?

In order to answer these questions an historical study was carried out which examined the problems in nursing and nurse education which clinical teaching was intended to alleviate, the reasons for seeking a solution to these problems in clinical teaching rather than by some other means, and the way in which clinical teaching has developed in the intervening years.

The Rationale of the Historical Study

In order to test the proposition that clinical teachers might have a conceptual image or 'ideal model' of what clinical teaching 'ought' to be which has its roots in the way in which clinical teaching was originally conceived, it was necessary to go back to the introduction of clinical teaching as a separate occupation within

nursing. This was an attempt to identify the ways in which clinical teaching was described at the beginning and to develop a profile of this new phenomenon at the time, the clinical teacher. Such an exercise, however, is fraught with difficulty. In the first place it may be difficult to determine what is the beginning. Even after having decided where to begin, it may be difficult to discriminate between what is relevant to the purpose of the study and what is merely interesting. Then having decided what is relevant it is necessary to present it in a way which preserves the multidimensional nature of a past that was just as varied as the present while still keeping the main interest in sharp focus. While a chronological sequence of events in the development of clinical teaching is discernable, to present it as a 'story' in this way would be misleading, partly because the route by which it reached its present state is neither straight nor clearly defined, and partly because it is not the historian's task simply to produce a chronicle of events. (Indeed much that is of relevance to this study would be lost by such a presentation) However, since nursing histories have recently attracted considerable criticism for being mere chronologies and on other grounds, it is worthwhile giving some consideration to these criticisms and to the nature of historical writing.

Criticisms of nursing histories

In their study of nurse membership of professional organisations and trade unions Bellaby and Oribabor (3) make some critical comments about the kind of nursing history which constitutes a search for origins. There are three main criticisms: that many nursing histories are self congratulatory; that the present is allowed to intrude unduly into the past; and that the method of selecting one strand and following it back to its origin

has the effect of stressing the continuities rather than the discontinuities of history and of oversimplifying what is a very complex subject. To these Davies adds an additional indictment of what she calls "a conventional form of writing nursing history" which offers a connected chronological narrative of events in that "Its focus is particularly upon individuals, leaders in the field, exceptional people who struggle against the odds and win." (4)

This kind of criticism is not unique either to these writers or to nursing history. Hall *et al* (5), for example have pointed out that much of the basic and standard literature dealing with the development of British social policy has suffered from these kinds of defects. There is by now a considerable body of writing in which historians and philosophers have discussed these inadequacies as well as, more generally, the meaning and purpose of historical writing, and the extent to which it is, and should be, influenced by the historian's circumstances, interests and assumptions, and by the times in which he lives.

In any historical writing it is necessary to take such criticisms seriously. Since this study has reached a stage where an attempt to identify the origins of clinical teaching and to trace the route by which it has come to the present appears to be a valid undertaking, Bellaby and Oribabor's comments in particular must be considered carefully. The rest of this chapter, therefore, discusses some of the assumptions which seem to underlie many of the conventional nursing histories and the criticisms which have been made of them. It then describes the approach which has been used for the present study and discusses the sources which have been examined.

The conventional nursing history has been an overview which has painted the picture with a broad brush and has, perforce, dealt in generalities. This style of writing lends itself to a narrative of events but allows little scope for the detailed analysis of specific aspects or periods within the whole. To some extent such generalisation is necessary. Because the human mind has difficulty in retaining numerous pieces of disparate and unconnected information, it will constantly try to create some kind of pattern in order to make sense of them.

The historian engages consciously in this process, selecting from the myriad events of which he has knowledge those that are relevant to his purpose and presenting them in such a way that the reader can grasp their significance. As Elton puts it

> "what we call history is the mess we call life reduced to some order, pattern and possibly purpose. ..... whatever piece of the past the historian reconstructs must, to be present to the mind, achieve a shape of beginning and end, of cause and effect, of meaning and intent." (6)

In other words, the historian's task is not simply to produce an account of what has happened, but to explain how and why it happened as it did. This will entail identifying relationships and patterns, making comparisons and contrasts, ordering and categorising the material and making generalisations about it. It is important to note here that while the historian will present the criteria and analysis by which the material was selected and ordered and will declare the purpose and the possible limitations of any generalisations, the writers of conventional nursing histories have been severely criticised for their failure to do this and for dealing in generalities rather than in carefully explained generalisations.

Even so, there are a number of dangers in the legitimate historical process of analysis and generalisation. In the life of any individual or group many things happen which are not connected and there may be sudden changes of direction or fresh beginnings which do not evolve directly from what went before. With hindsight it may be all too easy for the historian to impose a pattern on such events which was not apparent at the time and which will falsify the evidence by suggesting relationships and continuities which did not in fact exist. It is equally easy when concentrating on major events to give the impression that they were the result of concerted effort and of rational planning by ignoring other events which led up to them - the conflicts of interest, the wrong turnings, the false starts, which may have had a profound effect on the shape of things to come. Similarly, a generalisation that is too ready or too sweeping can imply that, for example, the opinion of the majority or the common pattern of behaviour at the time were the only ones that were important, or even, that they were the only ones in existence. The problem in this case may not lie in the selection and presentation of data, since the behaviour and opinions of the minority are not always well documented and detailed information may never have existed or may no longer exist. Nevertheless, that in itself is not a justification for assuming that, if there is a likelihood at all that minority views existed, they were of no significance at the time.

Generalisation, then, can distort what it is intended to explain, and this is the more likely if analysis is sacrificed to the need to present a cohesive narrative. Unfortunately nursing histories which present a broad view of the way in which nursing has developed since the mid-nineteenth century have often fallen into this trap

as well. All too often they have assumed that nursing can be seen as a single occupation and have glossed over or ignored the real complexity of the subject. Indeed, many histories have dealt only with general hospital nursing and have made no more than a passing reference to nursing in other settings. More recent writers acknowledge that rather than there being one homogenous occupation called nursing, there are a number of very different groupings under that title and that these have very different origins and antecedents and have followed different and sometimes conflicting routes to the present. (7,8)

It is not, however, only between the various branches of nursing that there have been differences. Even within these branches there have been wide regional and local variations as nursing staff have adapted their practice and behaviour to meet local circumstances, although, these are seldom considered in the 'general history' of nursing. Often it is only the 'official' view put forward by those who are considered to have been nursing leaders which is discussed, although that may only represent the views of a small and, perhaps, atypical minority as is the case, for example, when evidence is based on data from the London teaching hospitals and does not take account of what was happening in the much more numerous provincial hospitals. As indicated earlier, this may well be due, to some extent, to the more ready availability of data about the teaching hospitals and the assumption inherent in some of them that the patterns adopted by the London teaching hospitals were common to other hospitals and regions. It is understandable that when attention is focussed on the main landmarks and major events of a period, it is assumed that policy always precedes action but this, too,

is a generalisation which must be made with caution, for it may be that the arrangement of material which provides such a logical and cohesive narrative does not accord with reality. It is by no means unknown for policy to derive from action that has already become accepted practice. More will be said about this later. (Chapter 6)

The recent reaction against generalisations of these kinds in nursing histories and the concentration on hitherto unexplored aspects of nursing history is increasingly challenging the notion of a cohesive group moving together, or, at least, in the same direction, towards common goals, and is revealing a much less 'tidy' and much more complex pattern of development.

Enough has been said to show that some of the criticisms of nursing histories attack not so much the search for origins *per se* as the concentration on narrative at the expense of analysis which results in oversimplification.

Another charge which needs to be answered is that nursing histories are commonly self-congratulatory. Questions relating to the possibility of achieving 'ultimate' history and the extent to which the historian's own purposes, circumstances and prejudices will affect the questions which are asked, the sources which are consulted, the data which are selected and the interpretation which is put on them have been discussed elsewhere. (see for example 9, 10) The completely objective history probably does not, and cannot, exist, for the historian is a child of his own times and must share the outlook and attitudes of his day just as he must be affected by his own experiences and circumstances. That does not mean that all history is a matter of private choice and interpretation, but it must be recognised that

> "The most severely analytical history based, as it would seem, directly on statistics by a bloodless scholar who seems to be troubled by no bias and no

> human feeling is nevertheless the result of a series of decisions in the selection and presentation of evidence and in the deductions to be drawn from it which must be affected by the personality and predilections of the author."(11)

If this is true of works of careful scholarship it need not surprise us that it is noticeable in those writings which are intended as introductory texts or to mark special occasions, as so many nursing histories are. A sense of achievement fostered, perhaps, by a centenary, readily provokes self congratulation and this is reflected in a number of works whose authors have too readily allowed the contemporary mood to colour their understanding of the past, so that they portray the development of nursing as an advance from the bad pre-Nightingale days into the light of modern nursing. In recent years it has been fashionable to 'debunk Nightingale' but even this has tended to reinforce rather than challenge the assumption that changes in nursing were changes for the better and that 'development' can be equated with progress, since the progress has been assumed to have been from the blinkered Nightingale era to the more enlightened policies and attitudes of today. The idea of historical development being synonomous with progress was a very common one in the last century when it reflected the confident mood of the time and was also, no doubt, partly derived from the tendency of reformers to paint an unrelievedly black picture of conditions which they were trying to change. Two world wars and their aftermaths have shaken this confidence, and more careful research has relieved what had previously been seen as utter gloom. Modern historians, in any case, are more concerned to understand the past than to evaluate it in terms of present day values and pre-occupations. This change in the study of history has been slow to affect the writing of nursing history, but

in recent years a more reflective approach has developed which has challenged the assumption that changes in nursing have always been for the better. Traditional views of the ways in which changes were brought about are also being questioned.

The historian's purpose in examining the past will inevitably affect the kind of history which he writes. This is not only because it will lead him to ask one set of questions rather than another, it will also determine the focus which he uses. We have already noted that concentration on the major landmarks of a period - the passing of an Act of Parliament, the setting up of a new body or the 'official' introduction of a new policy - without questioning the processes which led to them can give the impression of a developmental process which is determined, or at least carried forward, through a series of timely responses to new situations. A change of focus, perhaps to the activities of one particular pressure group, can give an equally partial though quite different picture.

No one study can focus on every part of the picture or do justice to every aspect of the subject. It is essential that there is a main centre of attention, that one strand is pulled out of the tangle, to use Bellaby and Oribabor's metaphor, although to do it justice and to make sure that it is properly understood, it must be set in its context and its background must be properly drawn in. Just how much of the background is included and the kind of detail which is given will depend on the historian's purpose and his frame of reference. It is at this point that Bellaby and Oribabor are inconsistant. They suggest that to focus on one strand rather than another is simplistic and misleading. But then they themselves take "trade unionism rather than professionalism

as the topical interest and trace its origins and developments" (12) This apparent confusion seems to lie in the lack of differentiation between a focus of attention and a frame of reference. Even when the focus is on the same 'strand', different details may be seen and a different interpretation given when various frames of reference are used. Versluysen brings out this point very clearly when she claims, for example, that

> "To date, most history has addressed the past solely from the point of view of men, male interest, values and concerns. ..... Feminist scholarship is slowly pinpointing women's interests on the map of history" (13)

The same point is made by Maggs (14) when he notes the attempts to link the development of nursing to sociological themes such as the nature and development of professionalism.

If the conventional form of nursing history, the continuous narrative, was inclined to exhibit the evils of over-simplification and over-optimism, it must not be assumed that concentration on more circumscribed aspects of nursing rather than on the way in which it has changed through time will of itself provide the antidote. Description which is based on a more detailed study of a wider selection of sources will certainly go some way towards redressing the balance, but it will also require a more analytical approach than has sometimes been apparent. This goes further than the asking of more searching questions, it also demands that the historian identifies and challenges his own biases and pre-conceptions.

The whole of the present study arose out of an association with clinical teaching and clinical teachers over a number of years. The historian can be thought of as an observer of the past, noting, recording and analysing those parts of what he observes that seem to him

to be relevant. Any direct experience of the events to be considered can be expected to predispose the historian to the same kind of problems which may be experienced by the nurse who acts as a participant observer of nursing. This indicates that there is a constant need to challenge assumptions and to question conclusions. But the direct experience can also lead to a greater understanding of the sources being examined.

It would be possible to use clinical teaching as the vehicle for an examination of the problems which beset nursing in general and nurse education in particular during the post war years. The focus of this study, however, is on clinical teaching itself, though it must be seen against a background of general hospital nursing and in the context of nurse education. The historical part of the study is a search for 'beginnings' rather than for 'origins', at least as the latter term is defined by Bloch "In popular usage, an origin is a beginning which explains. Worse still, a beginning which is a complete explanation." (15) While the past cannot provide a complete explanation of clinical teaching as it is currently practised or thought about, it can contribute to our understanding of it, for we all accumulate the experiences of past generations and these experiences affect not only our present circumstances but also the ways in which we react to them. To a large extent, too, the present is built on and shaped by the past. This part of the study, therefore, attempts to identify the 'shape' of clinical teaching in the post war years - the problems to which it was in part a response, the reasons for seeking their solution in clinical teaching rather than by some other means, and the way in which it was implemented. It also tries to identify the ways in which that shape changes and the forces which were brought to bear upon it.

In doing this, however, it does not attempt an exhaustive account of clinical teaching. Elton (16) suggests that a historian should, after defining the main area of study or line of approach, keep his mind open until he has immersed himself in his data so that the evidence itself will suggest questions which he can then pursue specifically. This approach does, of course, fit in with the general methodological development which this study seeks to explore and to demonstrate. However, the historical part of the study was designed specifically to answer two particular questions (see page 52) and, although the evidence has, indeed, raised other questions, these must be left to form the basis of future studies. This does not mean that only evidence which was thought to bear directly on the premiss was sought or considered. The sources were reviewed for everything that might have been relevant to clinical teaching, but the final analysis has been directed towards the identification of the presence or absence of a model or pattern of clinical teaching rather than to a consideration of all its facets or of its reflection of the broader issues and concerns of the time.

The sources which have been consulted are of various kinds - for the most part, articles, letters and editorials in the nursing and medical journals, reports of conferences and study days, official reports and the reactions of various groups to them. This kind of evidence, which was produced <u>at the time</u>, can provide both direct and indirect contemporary evidence of conditions and events but it must be used with caution. Two problems in particular must be considered - the purpose of the author or authors in writing it, and the kind of bias, distortion or editing to which it has been subjected. None of the material, with the possible exception of the official or semi-official reports was

primarily produced for posterity, and much of it was not intended specifically to shed light on clinical teaching. Nor can it be taken to be representative of the conditions or views of the time, for only a small, and possibly atypical, proportion of nurses, or doctors, write to or for journals. The content of letters and articles and the selection of material that goes into reports of meetings will be affected not only by the originators' position, experience and outlook but also by their purposes in writing and may also have been subjected to editorial cutting and rearrangement. While these problems are common to all of the sources mentioned here, each has its own particular problems which are dealt with individually.

The Sources

Official reports are readily available in nursing. Since the Lancet Commission on Nursing produced its report in 1932 (17) nursing has been the subject of a great variety of enquiries, some sponsored by government or statutory bodies and some by other organisations such as the Royal College of Nursing.

The early reports suffer from two major defects. In the first place, they seldom give any information about how the material comprising the report was obtained, so that it can be difficult to know whether they are stating opinions of committee members or whether the findings are based on enquiry or research. Secondly, even when they do indicate that there has been some kind of investigation, there is rarely much detail given about the methods used or the sizes of the samples, so that it can be difficult to assess whether the conclusions can be applied to nursing as a whole or only to one kind of hospital or region.

Journal articles are even more plentiful. These fall into two groups. Those which deal specifically with the issue of the professionalisation of nursing and those which deal with more general aspects of nursing and nurse teaching. The first group, which tends to date from rather later than the second, really forms the beginning of a much larger body of writing on this subject. This debate continued throughout the nineteen sixties and seventies on both sides of the Atlantic and could profitably form the basis for another study. The other group contains articles dealing with various aspects of nurse training, the way in which nursing was organised at ward level and the quality of patient care. These articles are written by both nurses and non-nurses. It should not be assumed that they necessarily form a representative sample of nurses' opinions or of opinions about nursing, but a number of the opinions and assumptions are common to many of them and as at least some of the authors were nurses in positions of influence, to that extent they can perhaps be taken to reflect more general opinion and to indicate likely trends.

The correspondence columns of the journals provide a useful comment on contemporary events. Much the same can be said about letters as about articles, except that they are nearly always prompted by some specific event or comment and may therefore represent a relatively spontaneous reaction rather than a carefully thought out argument. Many of these writers, too, seem to share common opinions and to that extent they may reflect more widely held opinions.

Reports on conferences, speeches and official papers which address themselves to relevant topics are useful but they need to be treated with caution. Speeches and discussions are themselves likely to have been less closely structured than articles which have been specifically written and revised for publication. In addition they are more likely to have been condensed and perhaps distorted in the reporting process. Therefore, they are less likely to convey an accurate impression of their originators' view than the items considered above. Nevertheless, they do provide some information about the way people were thinking at the time, although the extent to which they reflect accepted opinion or forward thinking must be in doubt.

Personal reminiscences have been given considerable emphasis in recent historical writing. Working in any hospital at the present time will be some nurses who were in post or in training during the nineteen fifties and sixties. Some of these were asked to describe conditions of work and patterns of training at that time. In this kind of data collection conventional sampling techniques were thought to be inappropriate since the population is in some respects self-selected by having remained in nursing for this length of time. The only attempt at randomisation therefore has been to ensure that respondents were working in different parts of the country and different hospitals.

The value of this kind of modified life history is that it "clothes" the data available from other sources. Although memory tends to fade with time, most of this fading occurs during the first few days and there is evidence to suggest that for many purposes interviewing over a gap of many years does not present worse unreliabilities than retrospection over less than a

year (18). Recall is, of course, an active process which can be stimulated by such things as meeting an old acquaintance, visiting the scene of an event or, as in this case, suitable questions and comments. When an event is highly charged emotionally some sort of restructuring or editing is effected so that on recall the memory loses some of its detail and sharpness. In addition there may be both a conscious avoidance of distasteful facts and an unconscious repression of material which is distressing. Since for this study, a broad general picture of conditions prevailing at the time was all that was required, these problems were felt to be of relatively minor importance. Of rather more concern was the fact that earlier memories tend to be "overlaid" and blurred or distorted by later experiences especially if these are similar in nature. In practice, it was found that most of those interviewed remembered and could identify memories relating to their first training best, and that the first year of training was clearest of all.

References for chapter three

1. Nurses and Midwives Whitley Council (1976) Pay and Conditions of Service. Whitley Councils for the Health Services. H.M.S.O. London. p 10

2. Benne K.D. and Bennis W. (1959) Role Confusion and Conflict in Nursing: what is real nursing? American Journal of Nursing 59:3 (March) pp 380-383.

3. Bellaby P. and Oribabor P. (1980) The History of the Present - contradiction and struggle in nursing. in Davies C. (Ed) Rewriting Nursing History. Croom Helm. London

4. Davies C. (1980) Rewriting Nursing History. Croom Helm. London.

5. Hall P., Land H., Parker Roy, Webb A. (1975) Change, Choice and Conflict in Social Policy. Heinemann. London.

6. Elton G.R. (1967) The Practice of History Methuen. London. p 96

7. White R. (1978) Social Change and the Development of the Nursing Profession. Henry Kimpton. London.

8. Carpenter M. (1980) Asylum Nursing before 1814: a chapter in the history of labour. in Davies C. (Ed) Rewriting Nursing History. Croom Helm. London.

9. Carr E.H. (1961) What is History? McMillan. London.

10. Clark Kitson G.R. (1967) The Critical Historian Heinemann. London.

11. *Ibid* page 67

12. Bellaby P. and Oribabor P. (1980) *op. cit.*

13. Versluysen M.C. (1980) Old Wives' Tales. Women Healers in English History. in Davies C. (Ed) Rewriting Nursing History Croom Helm. London.

14. Maggs C. (1980) Nurse Recruitment to Four Provincial Hospitals 1881–1921 in Davies C. (Ed) Rewriting Nursing History Croom Helm. London.

15. Bloch M. (1954) The Historian's Craft. Manchester University Press. Manchester.

16. Elton G.R. (1967) *op. cit.*

17. The Lancet (1932) The Report of the Lancet Commission on Nursing. Lancet Lancet 1 pp 415,417, 532,585.

18. Thompson P. (1974) Problems of Method in Oral History. Oral History 4 pp 1-47 Reprinted in Open University Offprint for D301 Historical Data and the Social Sciences

CHAPTER FOUR

THE PROPER FUNCTION OF THE NURSE

The Crisis in Nursing

In order to test the proposition that there is an historically derived clinical teacher role, it was necessary to establish a date for the introduction of clinical teaching. This, however, proved difficult, since, although a certificate of registration as a clinical teacher was first made available to clinical teachers in Britain by the General Nursing Council for Scotland in 1962, it is evident from contemporary nursing journals that clinical teaching was already well established in some parts of the country by then.

Four years previously the Scottish Board of the Royal College of Nursing had introduced a six month preparatory course, "with the blessings of the College Council, the Department of Health for Scotland and the General Nursing Council for Scotland" (1) but again it is evident from the nursing journals that, although it was unknown or very new in some places, clinical teaching was well established in others at that time.

This story is repeated if we go back to 1955 when a Scottish Government committee recommended the introduction of clinical teachers, or clinical instructors, as they were then called (2). Prior to that date there had been much discussion about the advisability of introducing such a grade, and some clinical teachers had already been in post for several years, although in other hospitals it was a novel idea.

To some extent this variation from one hospital to another and one part of the country to another was to be

expected. Until the creation of the Emergency Medical Service just before the second world war, each hospital or group of hospitals was self governing and independent and there was no attempt to provide a national nursing service, even in the municipal hospitals. In such a system knowledge of innovations spread slowly, and in any case hospitals were very much bound by tradition and local practice. Although there were two weekly nursing journals in existence, they were not, at that time, used as a forum for debate and exchange of information, as the medical journals were. Indeed, nurses who wanted to raise serious questions of nursing policy frequently did so through the pages of the medical journals, leaving the nursing journals for chatty views and news and clinical articles, in the main written by doctors.

The 1955 Report (2) was a consideration of a job analysis of the work of nurses in hospital wards carried out by the Nuffield Provincial Hospitals Trust and published in 1953 (3), which was itself a result of the report of the "Wood" committee on the recruitment and training of nurses, published in 1946 (4). For the purpose of this study, it was decided to go back to that report to ascertain the state of nursing and nurse training at that time and to identify, if possible, the reasons for the emergence of clinical teaching and clinical teachers as a separate entity.

Prior to 1948 many hospitals had difficulty in attracting and retaining staff. Although there is some evidence to suggest that this was due to an increase in demand rather than to a reduction in the numbers coming forward for training (5), it was considered at the time to be a problem both of inadequate recruitment and high 'wastage'. The term wastage seems to have been applied to the loss of trained staff from an individual hospital as well as to the loss of student nurses before the

completion of their training, but it is in this latter sense that it is usually understood.

Even during the early years of the Nightingale School a fairly high proportion of recruits discontinued training and this had continued to be a feature of most training schools. From 1932 onwards the twin problems of 'shortage' and 'wastage' had been the subjects of a number of enquiries and reports which put forward a variety of suggestions as to their causes and their solution. In general, these solutions were concerned with either the need for sufficient recruits of the 'right' calibre or with the conditions under which nurses lived and worked. For example, the Nursing Reconstruction Committee (6) was of the opinion that much of the wastage amongst student nurses was due to their inadequate educational background and it stressed that the whole standard of general education and intelligence of recruits should be raised. While that committee sought a solution in raising the standard of entry to nursing, other people suggested that it was the training itself which was at fault. To them, the solution lay either in a training which would make good educational deficiencies or which would be of a higher academic standard altogether (7). However, neither Carter nor any one else at the time seems to have given much consideration to the job which nurses were doing and the kind of preparation which might be most suitable for it.

By contrast, Barclay (8) considered that it was the recruitment process itself that was wrong. He felt that hospitals should make more effort to put forward an attractive picture of nursing. Indeed, a good deal of attention was paid to the long hours, hard work, rigid discipline and generally poor working conditions and relationships which, it was claimed, gave nursing a bad name, "... not only among young people in search of a

career, but also with their advisers, and with women in other professions" (9). These factors were also said to be responsible for a large number of recruits leaving during training.

The working party on the recruitment and training of nurses

It was a working party chaired by Sir Robert Wood which drew attention to the fact that the information on which these opinions were based was "inadequate, incomplete, misleading or non-existent" (10) and to the "... almost complete lack of reliable statistical data necessary" (11). This working party was appointed in January 1946 "to review the position of the nursing profession" in the light of the increased demand for nurses which the impending establishment of the National Health Service was expected to create. (Of the five members of the working party, two were nurses, both of whom were associated with London teaching hospitals.) As the introduction to the report suggests, the remit was wide and the working party was given considerable freedom in its choice of methods.

> "Our instructions were widely drawn and gave us the utmost freedom to determine the lines along which, and the limits within which, we should pursue our enquiry. We understood, however, that our objective should ... be ... to assess, if possible, what nursing force, in terms of quantity and quality, is likely to be required .... and to suggest how best that force can be recruited, trained and deployed." (12)

The resulting report provided a landmark in nursing history for two reasons: first, because it was the last report before the introduction of the N.H.S. and it explicitly looked towards the needs of the new system; second, and more importantly, because it was the first nursing report to base its conclusions and recommendations on

fieldwork specially commissioned for the purpose and undertaken by trained investigators. The report is quite critical, at least by implication, of previous reports -

> "Merely to add one more expression of opinion .... to the large number already in the field would serve little purpose. .... the best contribution we could make .... was to attempt to carry out a scientific study of the problems confronting the nursing professions. Our object has been, not to form impressions, but to discover .... facts" (13).

Rather more than half of the document is devoted to a discussion of the findings of the research, which was designed to establish the parameters of the existing nursing profession. It is perhaps not surprising in view of the emphasis put on shortage of staff and wastage by previous reports and of the preoccupation with these problems at the time (no doubt accentuated by the extra demands for staff occasioned by the war) that the working party assumed that wastage was the problem and set itself to discover the extent of this problem and its causes. The survey showed that this was even more of a problem than had been realised. In voluntary acute general hospitals 36% of the students left before the completion of training while amongst female students in mental hospitals the wastage rate was 82%. The working party felt that the situation was sufficiently grave to warrant the use of the term crisis and that it called for urgent action -

> "The nursing world is passing through a staffing crisis. .... It is here that the present system primarily breaks down. It is here that many of the other problems converge and it is in the solution of the wastage problem that the solution will be found for many of the other problems" (14)

The report identified four main causes of wastage - poor selection, poor human relations, poor material conditions and a training which was incidental to ward

work - and stresses that in any one case discontinuation of training was likely to be attributable to a mixture of reasons.

Although the working party estimated that as many as one in three of those who discontinued training might have been unsuitable in the first place and made recommendations about ways of improving selection, its main emphasis was on the need for changes in training and in the status of student nurses. However, in spite of being based on well documented research, and in spite of its fairly radical approach, the report contains an inconsistency which seems to lie at the heart of the 'nursing crisis' of which it speaks. On the one hand it appears to be taking a completely new approach to the study of nursing problems by asking "What is the proper task of the nurse?", but on the other hand it never really answers this question and its recommendations differ from those of its predecessors mainly in degree.

That it should be a new approach for a body whose purpose was to study nursing to ask this particular question is significant enough to merit more detailed consideration. Suffice it to say here that having asked the question the working party made no real attempt to answer it. In the course of a brief preliminary discussion of the health and social services in general and the economic effects of sickness in particular during which the need to establish the optimum size of the 'health' nursing service before considering the requirements for 'sick' nursing is emphasized, it was assumed that the main objective of the nursing service is the reduction of the incidence and duration of sickness, but that assumption was not made explicit. While such an objective seems to be a perfectly reasonable one to ascribe to the health services as a whole, it is less certain that it

can be applied directly to nursing without some kind of qualification. The working party, however, neither qualified it nor made any attempt to test its validity for nursing, yet presumably their whole argument for a revised pattern of training was built on the premiss that such an assumption was valid.

In discussing nurse training the question, "what are the chief characteristics of the good nurse?" was posed, but the research designed to answer it appears to be rudimentary and based on the kind of opinion which the working party found so unsatisfactory in earlier reports. That this was the only attempt to answer such fundamental questions is unsatisfactory for it provided a poor basis on which to rest their recommendations.

For all its apparently radical approach, the proposed new training was an adaptation of the old one and the report tacitly assumed that although there was unnecessary and wasteful overlapping between trainings for the General and Supplementary Registers and although there was far too much domestic work and too many repetitive tasks, demanded by the needs of patient care rather than of training, the existing system was basically the right one and really only needed to be streamlined.

When it came to the administrative framework of training, however, the proposed changes ran counter to this assumption, for the structure which emerged was based on an 'educational' model rather than on the existing 'service' model -

> "Student nurses would cease to be employees of the hospital and would not be bound by contract to an employing authority." (15)

> "... instead of training being incidental to their work in the wards, the service they render to the hospitals becomes incidental to their training ..." (16)

In other words student nurses should have student status. A system of regulatory and advisory educational bodies should be created to support this, in effect separating nursing service administration from nursing education administration. This represented a significant ideological as well as a practical change in the administration of nurse training, yet the working party did not seem to realise that it was recommending these changes without having settled the question of what nurses were to be trained for and what the most appropriate preparation for that work might be. It was left to the dissenting working party member, Dr. Cohen, to challenge the whole basis on which nurse training was established in a minority report.

> "Evidence from the job analysis shows fairly definitely that the average nurse who is now trained in three years or more could be even better trained in two years if the system of training were to be completely recast .... What the job analysis does *not* prove, however, is that a two year period of training is necessarily the *correct* period .... It is impossible to determine the content of nurse training before deciding what is the proper function of a qualified nurse." (17)

The minority report

Although subscribing to much of the main report, Dr. Cohen felt that it left unexamined certain key problems the solution of which was an essential condition for the planning of the nursing service. These key problems which he went on to discuss were:-

- the need to plan the nursing service in relation to other health services and the country's manpower and other resources.
- the need to consider hospital nursing in the context of the organisation of the hospital as a whole, and to determine what should be the function of the hospital before going on to the function of the nurse

- the absence of any criteria on which to base an estimate of either the total nursing needs or the relative demands of curative and preventative services

- the inadequacy of opinion as a basis for policy making.

As we have seen the majority report drew attention to the fact that many of the reforms previously advocated had had no basis in scientific or economic evidence. Nevertheless, Dr. Cohen felt that, in spite of recognising this, the report followed much the same pattern as its predecessors.

> ".... notwithstanding the great value of the detailed information in the Hospital Surveys, little is offered in the way of a sound framework for planning the nursing or other health services although this was apparently their first objective" (18)

Having discussed at some length the problem created by this resistance to applying research methods to nursing he tried to grasp the nettle which the majority report avoided. How, he asked, can nursing effectiveness be measured? Only by doing that, he thought, could one begin to consider which factors contributed to effectiveness and then make reasoned decisions about selection and training.

Dr. Cohen assumed that the duration of a patient's stay in hospital was an index of the duration of his illness and claimed that that was the only objective measure of the task of doctors and nurses. He then considered the implications of using this criterion as a measure of nursing effectiveness. His whole argument is perhaps best summarised in section 19 of his conclusions -

> "The function of a nurse is to reduce the incidence and duration of sickness. This definition of nursing provides criteria (e.g. duration of patient stay) for i) measuring the effectiveness of nursing care ii) determining the validity of possible

> selection procedures and iii) determining the content, methods and duration of nurse training."(19)

Although his assumption that the length of a patient's stay in hospital or the duration of his illness can, of themselves, be used to measure nursing effectiveness in this way, must certainly be challenged, Dr. Cohen's analysis was a useful one for it raised the fundamental question - how can nursing effectiveness be measured? - which was seldom considered in later reports. And, in an attempt to provide an answer, Dr. Cohen shifted the emphasis away from wastage to the more fundamental problems of the nature and purpose of nursing.

Reaction to the working party report

The working party report attracted considerable attention and was commented on in the nursing press and in memoranda from all the main nursing, medical and health care organisations. Most of these were sympathetic to the report, although considerable concern was expressed about some of the details and some raised the same kind of questions which Dr. Cohen addressed in his report. Indeed so many of Dr. Cohen's points had already been touched on by the time the minority report was published that it attracted less attention than it deserved. So much so that, as the Nursing Mirror commented, the minority report

> ".... rather tends to take its place in our minds alongside the other numerous memoranda on the Report which have appeared in the interval between." (20)

By far the most critical comment came from the King Edward's Hospital Fund. Starting from the proposition that "the primary task of a nurse is to care for the sick and helpless under medical direction" it condemmed the report on four

counts - its bias towards public health work for nurses rather than the care of the sick, its interest in nursing techniques rather than in the nurse-patient relationship, its concern with wastage during training rather than the failure of hospitals to retain trained staff, and the feasibility of giving nurses in training student status (21). This memorandum, which was supported by the Lancet (22), was one of the few which commented on the report as a whole. Most of the others concentrated either on some aspect of the proposed two-year training or on the failure of the working party to come to deal adequately with the question of the proper task of the nurse.

Reaction to the new training proposals varied from regret that the proposed new training units would be so much more impersonal than the traditional hospital training school (23) to concern that, no matter how desirable, student status for nurses in training would be impracticable. Although it would be ideal that students' experience during training should be determined by their educational needs rather than by the staffing needs of the hospital, the difficulties of replacing students by sufficient numbers of skilled orderlies would be too great. However, although some of the implications of "student status" are made explicit in the report, there is no clear description of what exactly was meant by the term, and it is evident from the reactions to it that there was a great deal of confusion as to just what was intended.

Few individual nurses felt strongly enough about the report to write to the journals (in spite of the Nursing Mirror's determined efforts to stimulate discussion), and for those that did the question was not so much whether the report should be accepted or not as when and by what means its recommendations might be implemented. The memoranda produced by nursing organisations show that,

although they had reservations about the training proposals, they were even more concerned about the lack of definition of the proper function of a nurse and the suitability of the kind of job analysis which the working party had commissioned. This concern is exemplified by the Nursing Mirror which, taking the working party to task for failing to treat their recommendations' implications for the staffing of the hospitals realistically, commented

> "... the job analysis which is really fundamental to the problem of providing a complete nursing service is that based on the patient's needs throughout 24 hours." (24)

The need to define 'nurse' and 'nursing' by analysing the needs of patients was also stressed in a memorandum submitted to the Minister of Health by a group of ten anonymous nurses who described themselves as experienced nurses who "have enjoyed special opportunities for observation of the problems associated with nursing". This 'Ten Group', as the Lancet called them, also pointed out that the working party's preoccupation with wastage during training rather than with the failure of hospitals to retain trained staff highlighted the weakness of a system in which the majority of patients in hospital were nursed by probationers.

Nor were the nurses the only ones to be exercised about the needs of patients. One of the Lancet's correspondents (25) was concerned that if the working party's recommendations were adopted the essential core of nursing would be lost and it is striking in view of the immediate results of the report, that he was also unhappy about the appropriateness of job analysis to the examination of nursing. He claimed that the primary tasks of the nurse of relieving pain and distress and of comforting the patient were the very ones which would not

appear in an analysis which merely accounted for observable duties performed. This whole discussion is best summed up by an editorial in the British Journal of Nursing in May 1948 which pointed out "that one can hardly analyse before defining the 'job' to be analysed seemed to be overlooked by many" and went on to comment that although the working party failed to answer the question of the proper task of the nurse it "does not hesitate to proceed to give details of the training deemed necessary." (26)

This failure to define the job before considering the preparation required for it was a feature of all the nursing reports from 1932 onwards. It goes some way to explaining their failure to find acceptable solutions to the problems which they considered. It was, however, only one aspect of the matter. Equally important was the confusion engendered by the use of the same terminology to describe different activities.

Many of those who wrote for the journals, both doctors and nurses, did try to describe what they thought nursing was, or should be, but even so there was a great deal of confusion as to what the term 'nursing' might mean and considerable difference of opinion about what nurses should be doing.

The Nature of Nursing

Dr. Cohen's assumption that the main objective of nursing was to reduce the incidence and duration of illness was not well received by nurses. They asserted that he was suffering from a "regrettable confusion" about the respective functions of doctors and nurses (27). Although it was admitted that these results did follow at least partly from nursing activity they could not be

regarded as its main objective which was to relieve the distress of illness. (28)

Both doctors and nurses tried to identify the essential nature of nursing and a clear difference of emphasis can be detected between these two groups. The doctors, understandably, saw themselves as having the key role and the nurses as being subordinate to them. For example, the Lancet, in its comment on the working party report, started from the proposition that the primary task of the nurse "is to care for the sick and helpless under medical direction" (29) and it went on to describe that task as "real bedside nursing". However in considering the way in which nursing impinged on their own activities the doctors were conscious that there was more to it than just providing them with assistance

> "Nursing comprises two main functions: one to minister to the patients' comfort; the other is to assist the doctor in safeguarding the patient and in the progress of the case." (30)

Some nurses, the 'Ten Group', for example, took this further by describing the nurse an an

> "interpreter, explaining the disorder to the patient; a hostess, seeing that he is at ease, housed and fed; the provider of mental and physical needs; a skilled assistant to the doctor; and a health teacher." (31)

But by no means all nurse writers were prepared to be so specific and in much of the literature the same terminology is used to suggest quite different kinds of activities, often with no clear distinction as to just which meaning is intended. The considerable confusion about what is being discussed which results from using the same word in different ways like this has already been referred to in the context of theory development. (page 10) As

was pointed out there, this is not simply a semantic confusion, for the activities to which the term 'nursing' are applied are, if not necessarily mutually exclusive, at least sufficiently different to require a different kind of practitioner.

At the present time three major kinds of activity may be implied.

1. *Direct care*, that is patient care of all kinds.

2. *Indirect care*, that is activities which enable direct care to take place. This includes the supervision of direct care, the administration of wards and perhaps nursing services as a whole, and teaching.

3. *Professional nursing* that is activities which are carried out by nurses but which, although related to direct and indirect care, are somewhat removed from them. Such activities include the higher levels of administration of nursing services, advisory work at national and international levels, political and professional work of all kinds, journalism and so on.

It should be stressed that the divisions between these kinds of activities are not always clear cut and that the terms themselves, when they are used at all, are often used very loosely. Indeed, the distinction between indirect care and professional nursing has only been clearly discernable in more recent writing. In discussing the use of the term 'nursing' up to about the middle of the century therefore, it is more accurate to describe two categories, direct care and professional nursing, with the latter term including indirect care. Figure 6 summarises the relationship of the various terms.

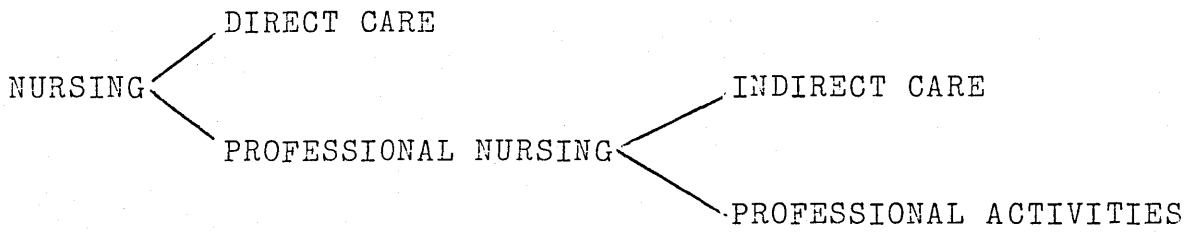


Figure 6 Uses of the term 'nursing'.

During the mid-century period which we are considering, it was the Royal College of Nursing report "Observations and Objectives" which came closest to differentiating between direct care and professional nursing. In its separation of the provision of patient care and the enabling of someone to provide it, it claims that

> "the two requirements of nursing are to find and equip enough people to perform the actual nursing and to provide leaders, who amongst other functions, will teach and direct the necessary numbers." (32)

The concept of professional nursing met with little understanding and less sympathy from medical staff.

> "One might wonder whether it would not be more proper to retain the word 'nurse' for the person who really nurses and find some new title for this officer grade? .... what is wanted are many more ordinary nurses and a few who by post-graduate training have the capacity to take charge of wards, etc. This latter group is a very small proportion of the former." (33)

A distinction which medical writers preferred to make was between what Brooke and Westenhall called 'skilled' and 'unskilled' nursing, apparently ascribing 'skilled' to those functions which related to assisting the doctor and 'unskilled' to those concerned with the comfort of the patient (34). No doubt this attitude of the medical

staff contributed to an attitude discernable in the writing of many nurses, that the functions associated with direct care were in some way inferior to the more technical aspects of care. In most of the larger training schools it was the student nurses who formed the bulk of the nursing staff and who provided most of the direct care, while elsewhere growing numbers of untrained staff were being employed to supplement the numbers of students. The much smaller proportions of trained staff in all hospitals and the consequent need for them to spend much of their time supervising students and untrained staff, could lead to a situation in which they no longer saw direct care as being part of their responsibility. A point of view which was supported by the Rcn in its comment of the Nuffield Job Analysis.

> "The College does not accept the view put forward in the Report that the person who should carry the weight of bed-side care is the State Registered Nurse - that it is her proper task ..." (35)

Whether it was seen as her proper task or not, however, it was certain that the job for which she was being trained was direct care rather than the management of those people who would carry out the direct care. It is hardly surprising therefore, that there was dissatisfaction amongst newly qualified staff who felt that they were expected to carry out duties for which they had not been prepared. (36,37)

The Rcn itself recognised this dissatisfaction -

> "As inability to concentrate on the personal care of the patient may be an important cause of dissatisfaction among newly qualified staff, research should be undertaken into the best type of group or patient assignment." (38) -

but it does not appear to have recognised the inherent anomaly in its own preoccupation with amending the way

in which nursing was organised without attempting to match the preparation of the nurse with the kind of work which she was expected to do.

Perhaps in view of these difficulties and the divergence of opinion amongst nurses themselves as to the nature of nursing, it is not surprising that previous studies had side stepped the question of the proper task of the nurse and had concentrated on conditions of service, or that the working party had failed to provide an adequate answer. However, having once been asked, the question could not now be ignored and job analysis was seen by many to provide the means to a solution.

Critics were quick to point out possible deficiencies in job analysis as an appropriate tool for the study of nursing.

> "The fact is that it is the comforting which is important to the patients, and it is the comforting which makes the most exacting demands on the nurse ..... yet it is the comforting which will not appear in any analysis made in terms of .... 'all the actual duties performed by the nurse'." (39)

That their technique could not be used to identify and examine the whole of the nurse's responsibility was recognised by the job analysis teams, though perhaps not always by those who advocated its use. That a more appropriate analysis would be one which considered the patients' needs over twenty four hours (40) was a suggestion which was ignored completely.

The Nuffield Job Analysis

The working party's study had been an extremely limited one and for this reason the Nuffield Provincial Hospitals Trust decided to assume responsibility for carrying out

> "a complete job analysis of the work of the nurse and other members of the health team in order to obtain the necessary data so that an answer may be given to the fundamental question 'What is the proper function of a nurse?'" (41)

Although it was originally intended as a study of the whole team this study, in fact, concentrated on the work of nursing and domestic staff in general medical and surgical wards and a few of the specialised wards which were used for the training of student nurses, and was published in 1953 under the title "The Work of Nurses in Hospital Wards: Report of a job analysis."

Although the question at issue was "What is the proper function of the nurse?", the report itself stresses that a job analysis can only indicate what is the present task of the nurse -

> "Between the 'present' and the 'proper' task of a nurse there is, however, a gulf which the mere statement of facts cannot bridge. The facts are open to more than one interpretation and the ultimate decision as to what is the proper task of a nurse, rests, as has been said, with the professions concerned." (42)

and suggested that it should form the basis for other similar studies and for further investigation of the proper function of the nurse.

> ".... the Trust hopes that individual hospital management committees may be minded to undertake job analysis of the nursing service of their own hospital or hospital groups as a means of ensuring the best foundation for their own nursing policies and administration" (43)

and

> ".... it cannot be too strongly emphasized that this study is not the end but only the beginning" (44)

The job analysis was carried out between 1949 and 1950 by a team of researchers none of whom had a nursing background. The work actually seen to be done in the wards was divided into categories which had been derived from observations made during the pilot study. These categories were defined as follows:

Basic nursing - care required in the interests of comfort and well being of the patient for the maintenance of health and prevention of infection, irrespective of the disease from which he is suffering.

Technical nursing - all nursing tasks concerned with the treatment of the disease from which the patient is suffering.

Organisation - work related to the running of the ward e.g. supervision, training and instruction of staff.

Domestic - cleaning and maintenance of the ward.

An analysis was then made of the time which each grade of nurse and domestic staff spent on each category of work. The unit of measurement was quite specifically the time taken to complete each task. The report dealt with three of the problems which this raises:

Firstly, a study of this kind, by its very nature, cannot account for all aspects of the work of the nurse, for example,

> ".... it is clear that an essential part of the duties of the nursing staff is to exercise constant vigilance towards the patient's condition, but this function cannot be measured in the same way as, for instance, their responsibility for providing the patient with food or toilet facilities. There are other things that belong in the same category: responsibility for overall supervision of staff; the extent to which tuition is given by example; keeping patients cheerful and confident of full recovery." (45)

and

> "Finally, there are social and psychological needs which have their origin in the fact that the individual has to adjust himself to his changed circumstances. The satisfaction of these is an essential part of his recovery. But, whereas the nursing tasks which satisfy the physical and medical needs of the patient are easy to recognise and classify the ways of meeting emotional needs vary widely and .... cannot in general be measured." (46)

Secondly, little or no account can be taken of the effects of peak hours or of the effect which unexpected happenings can have on the organisation and work of the ward -

> "The task of nursing the sick back to health is one of possible tension and crisis and the ward staff have to adapt themselves and their routine to any emergencies, while at the same time protecting their patients from the stress and excitement of such events" (47)

Thirdly, no assessment could be made of the effectiveness or quality of the work -

> "The technique of lay observation has ruled out any assessment of the quality of the nursing given: the time taken has of necessity been accepted at its face value although there were undoubtedly differences in the efficiency of different nurses" (48)

In view of the fact that the data from this report were intended to give a realistic picture of the present task of the nurse, these are important omissions, nevertheless the conclusions which the report draws are of interest.

The data were analysed in several ways to identify which grade of staff was doing which category of work, and also in an attempt to assess the effect of such things as numbers of staff in relation to the numbers of patients,

patient dependency, equipment and ward design. From this analysis it was quite clear that the qualified nurses were doing very little "basic nursing" as defined in the report

> "If by nurse is understood the one who gives personal care to the patient, then there can be no doubt that the 'nurses' in the wards today are the student nurses." (49)

The report goes on to comment that since students were providing nearly four times as much of the direct nursing care as trained staff the

> "accepted function of the trained nurse is not, in the main, to nurse the patient herself, but to see that he is nursed." (50)

The other significant finding is the overall priority which was given to technical nursing even though it formed a smaller proportion of the total work of the ward than did basic nursing.

> "The modern tendency, ... is to regard 'the administration of medicines and the application of poultices' as the proper task of the skilled nurse and to delegate the routine care of patients to less highly trained persons. This tendency has been clearly revealed in the present survey" (51)

If the reaction of the nursing press is anything to go by, the report was received with consternation, yet, although it was discussed at some length in study days and conferences and in the pages of various journals, its findings were not challenged to any great extent. Indeed it was claimed by many that it merely proved what was already well known - that having trained, nurses became "not nurses but administrators, public health workers and teachers - anything but practitioners in bedside nursing." (52)

The last quotation is from a paper entitled the "Right Use of Nursing Power" which, like so much of the comment on the report, implied that what trained staff were doing was not what they 'ought' to be doing. The source of this 'ought' is not made clear. Indeed, this is the very question which the report itself was unable to answer, because, by its very nature, the job analysis could only deal with activities which nurses were seen to carry out. What the job analysis did do was to bring into the open the fact that what nurses were being trained to do was not what qualified staff were doing. This in itself was valuable because it could have provided the starting point for a re-examination of the structure and nature of nursing and the kind of preparation which was most appropriate. As the report put it

> "The value of an inquiry such as this is in the opportunity it gives to pause and examine critically the direction of current trends. In this sense a consideration of the present task of a nurse is an essential preliminary to the determination of her proper task in relation to present day needs." (53)

Unfortunately it was an opportunity which was not taken and nurses continued to speak as if there were some externally determined, recognisable entity called 'real' nursing which was distinct from, and contrasted with, what nurses were seen to be doing. Admittedly there were conflicting views about what 'real' nursing was. While some deplored the fact that trained staff were supervising basic care rather than providing it, others accepted this and wanted the distinction between the supervisors and the providers to be made more clearly. All too often, however, there is little distinction between 'what is' and 'what 'ought' to be', and no indication of what the relationship between them might be.

Already we can see that in the wider field of general nursing the debate about the 'crisis' in nursing which was argued at first in terms of shortage and wastage of nurses was confused by a lack of distinction between the two perspectives one of which considers the source of nursing to be the real world of practice and the other considers it to be in a mental construct of an 'ideal' (see page 10). In this we can draw a parallel with the idea of a 'real' or 'ideal' model of clinical teaching which may or may not have existed but which is different from and contrasted with clinical teaching as it is practised or thought to be practised.

In addition to identifying the issue of the proper function of the nurse the job analysis report also showed that, since the actual contact between trained staff and individual students was comparatively low, very little teaching of any kind could have been taking place. This was also well known. There had been concern for several years that the practical training which student nurses received was inadequate and haphazard, but the job analysis brought these problems into the open and changed the emphasis of subsequent enquiries and reports from concern about 'shortages' and 'wastage' to concern about the effectiveness of nurse teaching and especially the effectiveness of ward teaching.

Before we look at the immediate results of this however it will be helpful to trace, at least in outline, the way in which nurse teaching had developed as a separate branch of nursing since the Nightingale era, and to highlight those points which are pertinent to this study.

References for chapter four

1. News and Comment (1962) Nursing Times 58 (2nd March) p 254

2. Department of Health for Scotland (1955) The Work of Nurses in Hospital Wards H.M.S.O. Edinburgh

3. Nuffield Provincial Hospitals Trust (1953) The Work of Nurses in Hospital Wards: report of a job analysis Nuffield Provincial Hospitals Trust. London.

4. Working Party on the Recruitment and Training of Nurses (1946) Report (the Wood Committee Report) H.M.S.O. London.

5. Abel-Smith B. (1960) A History of the Nursing Profession Heineman Ltd. London.

6. Nursing Reconstruction Committee (1943) Report: 11 Education and Training (Horder Committee Report) Rcn. London.

7. Carter G.B. (1939) A New Deal for Nurses Gollanz. London.

8. Barclay J. (1946) Why No Nurses? Faber and Faber. London.

9. Lancet (1932) Report of the Lancet Commission on Nursing. Lancet 1 pp 415, 473, 532, 585.

10. Working Party on the Recruitment and Training of Nurses (1946) *op. cit.* p iv

11. *ibid* p 3

12. *ibid* p iii

13. *ibid* p 1

14. *ibid* p 35

15. *ibid* p 55

16. *ibid* p 57

17. Cohen J. (1948) The Working Party on the Recruitment and Training of Nurses: Minority Report H.M.S.O. London.

18. *ibid* p 16

19. *ibid* p 54

20. Nursing Mirror (1948) Nursing Problems and Dr. Cohen Nursing Mirror 88 (2nd Oct.) pp 1, 2.

21. King Edward's Hospital Fund (1947) Comments on the Working Party Report King Edward's Hospital Fund. London

22. Lancet (1947) Recruitment and Training of Nurses Lancet 47:2 (13th Sept) p 401

23. British Medical Journal (1947) The Future of Nursing British Medical Journal 47:2 (13th Sept) p 422

24. Nursing Mirror (1947) Working Party's Report on Nursing - 2 further consideration of some problems raised Nursing Mirror 85 (20th Sept) pp 451-2

25. Lancet (1949) The New Utilitarianism - from a correspondent Lancet 49:1 (7th May) pp 792-793

26. British Journal of Nursing (1948) Job Analysis British Journal of Nursing 96 (May) p 54

27. Davies E.A.B. (1948) Letter - Dr. Cohen's Minority Report Nursing Times 44 (11th Dec) p 917

28. McAllister W.M. (1948) Letter - Dr. Cohen's Report Nursing Times 44 (20th Nov) p 852

29. Lancet (1949) What is Nursing? Lancet 48:1 (10th Jan) pp 69-70

30. Brooke E.B. and Westenhall J.P. (1949) The Economical Use of the Hospital Bed British Journal of Medicine 49:1 (19th March) pp 491-493

31. Lancet (1948) Nursing Lancet 48:1 (10th April) p 565

32. Royal College of Nursing (1956) Observations and Objectives: a statement on nursing policy Rcn London p 3

33. Anderson T. (1957) Letter - The Future of Nursing Lancet 57:1 (5th Jan) p 45

34. Brooke E.B. and Westenhall J.P. (1949) *op.cit.*

35. Royal College of Nursing (1953) Comment on the Nuffield Provincial Hospitals' Trust Job Analysis of the Work of Nurses in Hospital Wards Rcn London

36. Sister Tutor (1952) Letter - What should nurses be taught? Lancet 52:1 (1st July) p 1166

37. Dan Mason Nursing Research Committee (1956) The Work of Recently Qualified Nurses Dan Mason London

38. Royal College of Nursing (1953) *op.cit.* p 13

39. Lancet (1949) The New Utilitarianism *op.cit.*

40. British Journal of Nursing (1948) *op.cit.*

41. Nuffield Provincial Hospitals Trust (1953) *op.cit.* p 12

42. *ibid* p 126

43. *ibid* p 4

44. *ibid* p 15

45. *ibid* p 25

46. *ibid* p 28

47. *ibid* p 25

48. *ibid* p 29

49. *ibid* p 133-134

50. *ibid* p 134

51. *ibid* p 127

52. Nursing Mirror (1953) The Right Use of Nurse Power Nursing Mirror 97 (12th June) p 7000

53. Nuffield Provincial Hospitals Trust (1953) *op.cit.* p 126

CHAPTER FIVE

NURSING EDUCATION AND TRAINING

Nursing Practice

Formal nurse training had developed in the 1860s under the influence of Miss Nightingale and the School of Nursing which she established at St. Thomas' Hospital. Miss Nightingale believed that nursing should consist of more than poultice making and the giving of medicines -

> "It (the word nursing) ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper choosing and giving of diet - all at least expense of vital power to the patient." (1)

She also stressed the meticulous observation of the patient and emphasised that these things had to be learned by practical experience.

> "the writer .... honestly believes that it is impossible to learn it from any book, and it can only be thoroughly learnt in the wards of a hospital" (2)

The system of training which she devised therefore leant heavily on the experience gained by working in the wards under the guidance and direction of a trained nurse who would herself be responsible for teaching practical nursing. This last point is important. It was not thought to be sufficient for the probationer simply to work in the wards, she was to be taught and her teacher was to be the ward sister who was responsible for the nursing service of the ward. At St. Thomas' Hospital the sisters who took part in the training programme were given an extra allowance paid for by the Nightingale Trust Fund in recognition of the part they played in the practical instruction of the probationers. Elsewhere,

no such funds existed, probationers and sisters alike were employed by the hospital and no extra allowances were made for teaching. Even so, the insistence on the importance of practical experience continued to be an important feature of the training, although, as we have seen, the amount of teaching actually done by ward staff, at least by the nineteen fifties, was debatable.

As medical diagnosis and treatment became more specialised and complex, and as nurses who were able to take a fuller part in the care of patients became more numerous, so the scope of the nurse's work increased. No longer was it enough for the nurse to have a knowledge of

> "domestic management .... the care of equipment; the training and supervision of servants; the principles and practice of cookery and the nice serving of food; the care of linen, old and new; and the ordering and care of stores." (3)

She also needed some knowledge of hygiene, anatomy and physiology, bacteriology, asepsis and sterilisation, and of the signs and symptoms and treatment of disease. Nurses began to be seen and to see themselves as having a role which was complementary to that of the doctor although it was still subordinate to it.

> "While it is true that a nurse should not be expected to diagnose disease, it is very important that she should realise the significance of the appearance of, and variations in, signs and symptoms. These signs and symptoms may have a different meaning in different diseases or in different groups of diseases, and unless the nurse has had an adequate contact with each of these groups she cannot render the service to patient and doctor which is expected of her. While she is not supposed to interpret signs and symptoms in terms of pathology, she must be able to assess with reasonable accuracy their importance, so that the appropriate action may be taken without loss of time." (3)

On the one hand, then, nurses participated in the medical care of the patient by making and reporting observations on his progress and by carrying out some of the necessary technical tasks. Some of these tasks were the direct result of developments in medical technology while others were traditionally medical tasks which the doctors delegated so that they could be free to take up new and more complex tasks. On the other hand, nurses were responsible for providing the physical and psychological support and comfort which the patient needed. In order to do this in the changed circumstances resulting from advances in medical and surgical intervention they had to acquire new knowledge and develop new skills. To a large extent these new skills were developed and learnt in the wards rather than in the classroom although they were gradually incorporated into the body of nursing lectures. Indeed, the teaching as well as the practice of nursing went through a number of evolutionary changes.

Nurse Teaching

Such classroom instruction as was given in the very early days took the form of lectures from the medical staff and, often, from the matron who usually supervised the training school herself. By the end of the century Mrs. Strong at Glasgow Royal Infirmary and Miss Lückes at the London Hospital had introduced a "preliminary training school" in which probationers received several weeks of instruction before being allowed to enter the wards.

> ".... the probationers will be taught and taught thoroughly by the Sister giving her whole time to the School, such details as general housework, bed-making and bandaging, the names and uses of

> splints, the uses of various instruments, appliances and utensils; the making of fomentations and poultices, the names and costs of dressings, invalid cookery, elementary anatomy, physiology and hygiene - in fact they will learn the right way of doing things from the beginning of their training." (4)

However, the need for this kind of programme of instruction was not generally recognised at the time. It was only after the establishment of the General Nursing Councils in 1920, that nurse training gradually became more formalised with nationally agreed syllabuses and examinations. By 1947 the provision of a preliminary training school had become compulsory, and programmes of lectures were arranged throughout the training period, for some, or all, of which, students might be withdrawn from the wards to attend study days or a lecture 'block' of several weeks.

Associated with these developments was the employment of sisters specifically to do the teaching. At first these sisters seem to have contented themselves with going over the doctors' lectures and explaining or expanding specific points from them, but gradually they began to take classes of their own. They also took over much of the day to day organisation of the training, although the matron was to remain the head of the training school for many years to come.

From the nineteen twenties onwards special preparatory courses for these teaching sisters were offered by the Royal College of Nursing in conjunction first with the University of London, and then also with the University of Edinburgh. In due course the General Nursing Councils were empowered to approve such courses and to offer a certificate of registration as a nurse tutor to those who successfully completed them.

It is clear that by the nineteen fifties there was a great deal of dissatisfaction about the position of these sister tutors. By this time there were three kinds of nurse teacher in employment in hospital training schools - the qualified nurse tutor who had undergone an approved course of training for the job and was registered as a teacher of nurses by one of the General Nursing Councils, the unqualified tutor who, although working full time in the school, perhaps even in some cases as the only tutor in post, had not taken a tutor's course and was not registered as a teacher of nurses, and, in England and Wales, the pupil nurse teacher. (This grade, which was never introduced in Scotland, was established when training for pupil assistant nurses was introduced. The pupil nurse teacher was not a qualified tutor but had taken a shortened teaching course and was employed only in assistant nurse training schools. In Scotland, after 1958, nurses successfully completing the Clinical Instructors' Course also qualified as pupil nurse teachers.)

In 1951, in response to concern about the shortage of nurse tutors, a joint committee was set up by the Minister of Health, the Department of Health for Scotland, the General Nursing Council for Scotland, and the General Nursing Council for England and Wales to survey the position. It showed that there was an overall shortage of teaching staff - the ratio of teachers to learners was found to be 1 to 52 in Scotland and 1 to 41 in England and Wales, but of these about a third were unqualified tutors. (The ratios which were thought to be appropriate were estimated by the Councils to be 1 to 44 and 1 to 35 respectively but no grounds for these figures were given in the report.) The report also showed that the distribution of tutors was very uneven: for example, in one training school consisting of four

hospitals and with 359 nurses in training there were 16 qualified tutors in post, while in another consisting of two hospitals and with 625 learners there were 6 qualified and 3 unqualified tutors (5).

The committee went on to consider various aspects of the function, status and preparation of tutors and its report, taken with the 'Memorandum on the Nurse Tutor' published by the Rcn Sister Tutor Section in 1953 (6), shows that there was a great deal of discontent amongst tutors.

As with nursing itself, there were a number of specific and fairly obvious reasons for this discontent although these can be seen as symptoms of a much deeper and more intractable problem.

Education or Training?

If wastage was a problem for nursing as a whole, it was very much on the minds of the tutors and this and the associated subject of selection received a good deal of attention. It was assumed that it would be possible to identify suitable nursing candidates if only the selection procedures could be improved. This usually implied the introduction of a minimum educational standard and, indeed, a later study does suggest that the success rate is lowest amongst those students who left school early without educational certificates (7). 'Success' here, however, means successful completion of training, not successful practice as a nurse, and in view of the stirrings of doubt about the relevance of current training programmes, one wonders just how realistic such measures were.

The Working Party on Recruitment and Training of Nurses (8) had estimated, on the basis of a survey of those who had recently discontinued training, that one third of those who 'wasted' were unsuitable for nursing in the first place, and even if these figures had a somewhat tenuous basis and were inflated by the war, they still leant support to the belief that the practice of some hospitals of accepting 'poor' candidates in order to fill vacancies, was to blame for a large part of the wastage. This practice was also blamed for lack of job satisfaction amongst tutors since it compelled them to concentrate on getting students through examinations to the exclusion of everything else.

> "The proper function of the Sister Tutor is the education of the student nurse .... By this is implied something wider than teaching for examinations .... failure to recognise this wider educational function is the greatest single cause of loss from the Sister Tutor's ranks" (9)

Indeed the whole question of whether nurses should be educated or trained was a recurring theme and it was closely associated with the question of what is meant by 'nursing'. On the whole, those who advocated 'education' seemed to be thinking in terms of professional nursing while those who favoured 'training' were thinking of direct care.

> ".... there should be from the beginning clearer differentiation between training the numbers required to staff the nursing service and preparation for leadership" (10)

This is probably too much of a simplification for, even at this time, there were some who advocated an undergraduate course for some nurses to "bring into the profession more trained minds with a broad outlook." (11)

Carrying as it does implications for the professional status of the tutor herself, the claim to be providing an education rather than a training was an important one for the tutor, and one which lay at the heart of the discontent identified by the 1953 Memorandum (12) and the 1954 Report (13). In addition to the problems of recruitment and 'wastage', these reports identified three main problem areas, all of which can be seen as aspects of the problem of the tutor's professional status and her concern to provide an education rather than a training.

Misunderstanding or lack of appreciation of the function snd status of the tutor.

Increasingly the nurse tutor was identifying with teachers in other spheres, and was finding that the organisation of the school of nursing as another branch of nursing service was inappropriate.

> "The Sister Tutor while taking into account the general welfare of the school and hospital, should be free to plan lectures, classes and visits on educational lines like teachers in other spheres of education." (14)

In endeavouring to treat the nurse-in-training as a student and to provide a truly educational environment, the sister tutor was continually constrained by the student nurse's status as an employee of the hospital with all the anomalies which that implied, not the least of which was an obligation to be seen to be 'on duty' for a fixed number of hours a day even during periods of full time study. Of course, this was also true of the tutor who often found herself in an untenable position, for the hospital and the school had different aims and norms and, above all, different organisational patterns.

> "..... it should be remembered that the plan of work for the school does not follow the same pattern as that of the other nursing departments of the hospital." (15)

Yet the training school was quite definitely thought of as one of the nursing departments of the hospital and the matron, who was responsible for the nursing service of the hospital, was also the head of the training school, even though she usually had no experience or knowledge of teaching. Surprisingly, although the results of this organisational pattern were a frequent cause of complaint, the basic pattern seems to have been accepted without question. In both of the reports under discussion there is certainly an assumption that this pattern would continue, even though the memorandum does advocate greater freedom of action for the tutor and more say in matters of training school policy. In reporting on a conference of nurse tutors held in January 1956 the Nursing Times notes that

> "Considerable concern and feeling was expressed in the discussion on the status of the tutor. It appeared that tutors were often not consulted on matters affecting training, they were rarely informed of G.N.C. correspondence or Ministry circulars. Many requested more contact with Area Nurse Training Committees." (16)

Yet there is no suggestion that anyone at the conference expressed the view that the matron should not be the head of the training school. If any such suggestion had been made, it would almost certainly have been reported as a radical departure from the *status quo*.

Professional status and promotional prospects

Status is closely related to conditions of service and to opportunities for promotion and in both of these

respects the tutor was disadvantaged, whether she was compared with teachers in other spheres or with nursing administrators. The comparison with other teachers did not stop at freedom of action and the organisational framework within which they operated, it included hours of work, holiday entitlements, public holidays, weekends off and, above all, salary. Nor, apparently, was it only the tutors themselves who saw anomolies in these.

> "For some obscure reason the sister tutor - qualified both as nurse and as teacher - is paid less than the administrative nurse and less than the school teacher who instructs the same girls at an earlier age." (17)

A suggestion was even made that the solution to these problems of status lay in the tutor ceasing to be a nurse altogether when she became a teacher. But the Joint Committee disagreed with this idea.

> "We cannot accept this point of view, in fact we believe that should such a hard and fast division of function be encouraged, the tutor will be unable to train the student nurse successfully in the profession which that student has chosen. This division and lack of co-operation between the theoretical and the practical side of the nursing profession is a potent cause of dissatisfaction among nurse tutors." (18)

It was not just the lack of co-operation between "the theoretical and practical side" which caused dissatisfaction. Tutors <u>had</u> to take a preparatory course, which, during the nineteen fifties, became a two year university course, while administrators did not <u>have</u> to take any further training (although many did).

> ".... in no other profession is the educator valued below the administrator .... A tutor <u>must</u> take a two year course while an administrator <u>may</u> take a course of one year. Until this state of affairs is remedied we feel justified in expecting a higher remuneration." (19)

As long as the matron remained the head of the training school and schools were associated with individual hospitals, moreover, there was little promotion for the tutor within nursing education, and her salary was fixed to a scale below that of the matron.

> "In the various branches of nursing - and perhaps in nursing alone - the teacher ranks well below the administrator: not only does the matron of the smallest training hospital actually receive a larger salary than any principal tutor but it even pays a principal tutor - after rising to the very top of her branch of the profession - to apply for a post as deputy matron of a moderate-sized hospital." (20)

For the tutor this question of her professional status was at the heart of her problems. Not only was she better qualified than her colleagues in the wards, but her relationship with the medical and other staff with whom she worked was of a different kind. No matter how autonomous the ward sister might feel herself to be in relation to the purely nursing aspects of the patient's care, a very large part of her work was determined by 'doctor's orders' and the tradition was strong that the ward 'belonged' to the consultant in charge and that she was 'his' ward sister. Similarly, in spite of the tripartite structure of the hospital administration, which was divided, in theory at least, amongst the hospital secretary, the medical superintendant and the matron, the matron seldom had a voice as of right in the deliberations of the board of management and her role in most cases was a supporting one. The tutor, on the other hand, controlled the training programme to which medical staff contributed. She invited them to lecture, told them, when, where and for how long, and ensured that they received their fees, and so, was, to some extent, in the position of directing the work, not only of nurses, but of other professional staff as well.

In the school, more than anywhere else in the nursing world at that time, the nurse saw herself to be in a position of equality with other professional staff. Yet it was an illusion of professional independence, for she was controlled by the matron within a rigidly hierarchical system and was subordinate to her in status, salary and promotional prospects. When compared with teachers in other professions she was very much the poor relation. If the various anomolies in nursing presented the tutor with well-nigh insoluble problems, it was in this issue of professional status that they were at their most acute.

Loss of contact with the nursing of the patient

We have seen that the content of the nursing lectures was developed from the new skills and procedures which were being practised in the wards as a response to changes in medical and surgical diagnosis and treatment. The ways in which these nursing procedures were actually carried out depended on the preferences of the particular ward sister and consultant as well as on the circumstances of the particular patient or group of patients. Thus considerable variation was possible from ward to ward and especially from hospital to hospital. This did not matter as long as the nursing was taught in the wards or at least by the ward sisters, but the sister tutors did not work in the wards. As we have seen, as more and more teaching was provided in the form of lectures and demonstrations and as the training programmes became more formalised, the tendency was for one or more sisters to be employed specifically for teaching and this meant that they gave up their wards and their commitment to patient care, although they might still visit the wards occasionally if time permitted. The tutors therefore were faced with the problem of retaining their familiarity with

the way things were done in the wards while spending more and more of their time in the classroom. The longer the tutor had been in post, the more likely it was that there would be a discrepancy between what she taught and actual local practice. This was particularly the case if the tutor had not herself trained or worked in the hospital before becoming a full-time teacher.

So, while tutors might cast envious glances at the pay and conditions of service of other teachers, and a few might leave the health service to work in colleges of further education teaching pre-nursing courses, for the majority the real problem was how to improve their professional lot as teachers while retaining their credibility as nurses. In solving this problem contact with the wards was a key factor. If, when they became teachers, they could not continue to have some responsibility for patient care, as the medical teachers could, they could, at least, retain access to the wards to oversee the students and to teach them there, and in so doing maintain their familiarity with the 'real world' of nursing. Not that this was necessarily easy to accomplish, for as we have seen there was an overall shortage of tutors and many of them were singlehanded. There were other problems, too. As one tutor put it

> "Perhaps nobody has ever taught in the wards - other than the sisters .... Perhaps we feel we have been away from patients for too long, and .... feel insecure; or perhaps it is geographically difficult ...." (21)

Nevertheless, just as it was assumed that the ward sister was responsible for the practical instruction of the students while they were in her ward, so it was assumed that the tutor would not work solely in the classroom, but would also 'visit' the wards and teach the students there, and though tutors themselves might deplore the fact

that they spent so little time in this way the assumption that they 'should' do so does not seem to have been questioned, at least until clinical teachers began to make an appearance.

Some tutors undoubtedly did visit the wards and it is clear from the little information which is available on this point that the teaching which they did there was considered to be quite different from the teaching which the ward sister was expected to do. (22) Some tutors may have worked with students from time to time, but more commonly they seem to have conducted ward rounds and 'clinics' similar to those which medical staff conducted with their students. (23) However, it is difficult to know whether references to this kind of activity described what was actually happening as Stevens (24) puts it in the "real world of nursing practice" or what the writers thought 'ought' to be happening in their 'mentally constructed world'.

Nursing Theory and Practice

It was not just the tutors who were concerned about professional status. As has already been mentioned (Page 89ff) the word 'nursing' was frequently used to infer professional kinds of activities related to care of the sick and there was an assumption in much of the literature that nursing should be accorded professional status.

One way of achieving this was by improving the academic status of nursing, and this the tutors tried to do both by claiming parity with other kinds of teacher and by emphasising the academic aspects of their teaching. Any claim to be offering a professional education, however, had to be justified by showing that nursing was based on a body of knowledge which had to be mastered before the nurse

could practise, or, at least, before she could be considered fit to practise on her own as a 'qualified' nurse. This raised questions about recruitment and entry qualifications as well as about the content of the training programmes.

The possibility that recruitment might be based on the ability to undertake the training rather than on suitability for nursing has already been discussed, but there was also a danger that in order to provide sufficient numbers of workers, hospitals would accept candidates who were unable to achieve the required academic standard thereby creating difficulties for the teachers and swelling the numbers of those who left without completing their training.

These problems were exacerbated by there being no nationally agreed minimum educational entry requirements which might have allowed the selection of more able entrants and the consequent raising of the standard of training.

> ".... nursing, by imposing no definite entrance requirements such as would be acceptable to the universities, has opened its doors to people who would find difficulty in profiting from a course of higher academic level. .... until an entry standard is adopted, the General Nursing Council has little choice but to adapt its examinations, subject to overriding considerations of public safety, to the abilities of the candidates rather than to an idealistic conception of the professional nurse." (25)

To be fair, the General Nursing Council had been seeking powers to raise the minimum entry requirements but had been prevented by fears that this would reduce the numbers of nurses in training to such an extent as to create even worse staffing problems than the hospitals already faced. But even more fundamental were the problems of deciding what it was that constituted 'nursing' and what should be the content of the training programme.

Even as late as the nineteen fifties nursing as an academic discipline hardly existed and much of the student's formal teaching, including her text-books, was still provided by medical staff. The syllabuses of the General Nursing Council and the formal programmes of teaching which they necessitated were based largely on borrowings from medical science, anatomy, physiology, hygiene, and such information from the social sciences as seemed relevant, together with the nursing skills and procedures which were being practised in the wards. Gradually the extent of these borrowings was increased to explain medical diagnosis and treatments and their associated technical procedures from which much of the nursing activity of the wards was derived. Unfortunately, no such explanations were sought for the nursing skills and procedures which continued to be learnt and practised by rote, so that increasingly the separation between the 'technical' and 'practical' aspects of nursing which the Nuffield job analysis noted in the wards (see page 94ff) was reflected in the school with the emphasis being placed more and more on the technical. In the wards the classification of duties according to the degree of 'scientific' knowledge or technical skill which was required to perform them and the allocation of the more technical tasks to the more 'senior' students increased the tendency to look to medical and biological science for knowledge rather than to examine the basis and content of nursing itself.

Of course, advances in medicine and technology meant that many nurses did need to have more technical knowledge, both to understand the technical aspects of their work and to recognise the significance of changes in the patient's condition, (26) and some nurses, at least, carried considerable responsibility:

> ".... often the only trained person awake is the night sister therefore she must have knowledge of drugs etc." (27)

Even so, some people were unhappy about this trend towards more and more technical knowledge. For example, Lord Amulree, in a debate in the House of Lords in 1953, felt that there was a danger that too many nurses were being trained to too high a standard (28), and that same year a doctor writing to the Lancet was even more outspoken -

> "Anyone who examines the content of the student nurse's curriculum must reach the conclusion that there is a danger that the modern general nurse is being transformed into a kind of unsatisfactory medical student." (29)

Many of the critics, both doctors and nurses, considered that nurses' lectures should be confined to information which was "truly relevant to a nurse's duties" (30) and they were concerned that the emphasis on professional education was producing training programmes which did not do this.

> ".... the formal training received by the student mental nurse bears little relation to the job of the trained nurse ...."(31)

However there was little agreement as to just what was needed and these differences reflect the confusion about the real purposes of nursing education.

> "Should we not then ask ourselves what do we really mean by the word 'nursing education'? Would you agree with me that many of us have little idea of what we want to effect by nursing education? Again, do we know what we are aiming at?" (32)

These questions could not be answered without posing the question of the proper function of the nurse and this was precisely the question which the Nuffield job analysis had raised, although its answer had shown what was the

actual rather than the proper function of the nurse.

Long before the job analysis team reported, however, concern had been expressed at the ready division of nursing into the two main functions of 'assisting the doctor' and 'ministering to the patient's comfort'. This concern was particularly acute when these functions were described, as Brooke and Westenhall, for example, did describe them in terms of skilled and unskilled nursing.

> "The aim of the hospital nurse is still, at any rate in this country, instinctively understood to be primarily the relief of pain and distress and the comforting of the patient, but this aim is being subordinated to a new conception .... to wit, that the nurse is primarily a skilled medical auxiliary .... and it is clear that the unskilled nursing which she is to delegate to others is precisely ministering to the patient's comfort .... The fact is that it is the comforting which is important to the patient, and it is the comforting which makes the most exacting demands on the nurse, against the demand of which her training should offer her support and guidance" (33)

The idea that skilled nursing might mean something different from, and more than, technical nursing is seldom made explicit until the nineteen seventies when nurses began to study and evaluate their own activities in a much more formal and objective way. Nevertheless, during the nineteen fifties many doubts were being expressed about the whole basis of nursing activity, and these frequently took the form of questions about the way in which nursing was organised and about the amount and kind of teaching which students were receiving in the wards. In both cases the initial questions seem to have come from. or at least to have been stimulated by, the Nuffield Report.

Clinical Experience

The emphasis which Miss Nightingale put on practical experience has already been noted (page 105). We have also seen that this emphasis was retained although the pattern of nurse training changed considerably over the years. There are two aspects of the use of practical ward experience as a part of the student's training for the job. One is the extent to which the pattern of ward allocation during the whole training period takes cognisance of the student's need to learn certain things at certain stages. The other is the kind and amount of actual teaching and learning which goes on in individual wards. While these aspects are different, they overlap considerably and are profoundly affected by the student's status as both learner and employee.

Student or employee?

Initially, in the Nightingale School, probationers may have been supernumerary to ward staff, (although even this is doubtful) but this was certainly not so elsewhere. As Carter put it,

> "Many of the hospitals did not really understand the Nightingale principles. Even at St. Thomas', as elsewhere, the needs of the hospital - not necessarily the true welfare of the patients or the best interests of the nurses - came to be paramount."(34)

In most hospitals students were relied on to make good shortages of other nursing staff and, where they were available, nurses in training often formed the major part of the work force in spite of nursing opposition as expressed, for example, by the Rcn in its 'Memorandum on the Nurse Tutor!

> ".... the College feels that the time has come to recognise the need for a different method of staffing

> the hospitals from the present reliance on students to carry the main burden of nursing service." (35)

This dual status of employee and learner meant that the students occupied two different types of organisational world. On the one hand they were 'students' whose prime preoccupation should have been to make the most of the educational opportunities which were available, but at the same time they were employed in an organisation characterised by a rigid hierarchy and a strictly routinised work schedule. Moreover they occupied a low place in this organisation in which education was also given low priority. Membership of these two organisations also created problems for the tutor who was not usually able to secure for herself or her students educational opportunities or conditions of work which were anything like those that were available to other kinds of student.

Being both student and worker gave rise to other problems which were at least mentioned by almost all the reports from 1943 onwards, and a good deal of attention is given to them in the journals during the nineteen fifties. Indeed, to some extent, the anomalies inherent in this dual status began to supplant wastage as the principal cause of concern.

> "The conflicting requirements of the sick patient and of the student nurse present perhaps the greatest problem with which the nursing profession is faced at the present time." (36)

Two main problems can be identified from the literature - the conflict of interest which resulted in the subordination of training to service needs, and recruitment - but they are not easily separated since each has a bearing on the other.

Given the nature of the nurse's employment, it was almost inevitable that the care of patients should present more immediate and urgent claims than did the student's training, with the result that training needs were subordinated to those of service.

> "It has to be recognised that at present the student nurse is almost invariably a 'student' in name only. First and foremost she is an employee of the hospital with which she signs a contract, and her training is largely incidental to her daily duties." (37)

This often affected the overall training programme as well as the training given in the individual wards.

> "There can be little doubt that each hospital arranges its particular training programme in the light of the nursing service requirements of the hospital, while at the same time endeavouring to ensure that the nurse undergoing training gains sufficient practical experience, ... most Ward Sisters are aware of this failure to provide scientifically devised practical training programmes, ... To this extent, then, the practical training of nurses is subordinated to the nursing service requirements of the hospital." (38)

What this meant in effect was that within the ward the allocation of duties to individual students was also often decided on the basis of service needs rather than of their educational value. ".... the allocation of duties to her was dictated solely by administrative necessity." (39) Because students were more likely to be allocated tasks which they could carry out without supervision than those which they still had to learn or gain proficiency in, there was considerable time spent on repetitive or routine tasks which students performed on their own or with other students. "Student nurses spend much of their time in carrying out routine duties from which they can learn very little." (40) Many commentators felt strongly that these kinds of tasks should be removed from the student nurse to set her free to follow a truly integrated

educational programme which would improve the standard achieved and reduce the length of time required to reach it.

> ".... so long as hospitals continue to rely on the student's labour educational time is dissipated and the standard of learning and practice attained is not commensurate with the length of time spent on training." (41)

On the other hand there were those who thought that these very tasks were of the essence of nursing and could not be removed from students without jeopardising the whole training programme. McNaughton summed up the dilemma neatly in a paper delivered to the International Council of Nurses Conference in 1949,

> "a nurse cannot be created by teaching divorced from practice, .. an ability to cope with emergency, organise routine and develop responsibility is dependent upon the experience and repetition of duties in the ward. How can we strike a balance which will ensure adequate theoretical and practical instruction so welded together that we produce a nurse with all the virtues of the old system and none of its faults?" (42)

In 1949 and for many years thereafter, with the student nurse very firmly established as part of the workforce, there seemed to be no answer to that question.

It is clear that there was a conflict of interest in the allocation of students to wards and in the allocation of duties to students, but it went deeper than that. The subordination of training to service also created a conflict of interest for the ward staff who were responsible for both the teaching of students and the care of patients, and for the students who were expected to see the immediate day to day care and treatment of

patients as part of the larger whole, and to link up various aspects of what they were doing with lectures which they might have had in class, perhaps many weeks or months previously. It is not surprising that both groups found it easier to attend to the immediate tasks of looking after the patients in their care to the exclusion of explicit teaching or learning.

> "With the ward sister care of the patient is a more important and urgent responsibility than teaching. It is easy for her to forget that her nurses are students as well as ward staff, to forget her responsibility for teaching and to minimise its importance. Likewise the student may become involved in the urgency of nursing her patients and forget that part of her total responsibility is to learn." (43)

In addition to these problems which affected the nurse in training and her ward teachers there was the temptation for the hospitals to accept for training candidates who were unsuitable.

> "Many student nurses are admitted for general training without the mental capacity to rise to the responsibilities borne by the general trained nurse." (44)

This whole question of suitability <u>for</u> training was of course tied up with that of suitability <u>of</u> training and as we have seen there is some doubt as to whether there was much correlation between the training given and the responsibilities for which it was the preparation, but the Rcn committee did have the evidence of the working party and of other studies of wastage to draw on in making the claim that

> "We may conclude that in this sample about 1 in every 3 of those who abandoned training before completing the course should not have been accepted at entry." (45)

The organisation of ward nursing

Associated with the emphasis on the student as a working member of the ward team were the practices of dividing nursing tasks into technical and basic, or skilled and unskilled (see Page 94) and of organising the work of the ward according to the tasks to be done rather than the patients to be cared for. Increasingly, differences between trained and untrained staff, senior and junior nurses, were seen in the types of tasks allocated to them. Junior students and ward orderlies were allocated domestic or semi-domestic tasks and many of the more intimate personal services for patients, while progressively more technical skills were needed to perform the tasks allocated to senior students and qualified staff. The advantage of this system was that untrained staff and junior students could be left to perform a limited range of tasks without supervision and it gave the appearance of accomplishing the work quickly and efficiently. However, the Nuffield report suggested that this was not a satisfactory way of providing nursing care because it was not in the patients' best interests.

> "The danger to the patient in insisting upon the separation of basic and technical nursing functions lies in the fact that both originate in human needs which inevitably react upon one another." (46)

Since different people were supplying the two types of care a coherent response to this interaction of needs was lost. This fragmentation of care caused concern because it could lead to a situation in which no-one really cared for the whole patient.

> "Each nurse observes a bit of each patient and reports this to the ward sister. The ward sister puts the bits together .... the sum of the bits may not give the dramatic whole." (47)

To some, this was not just undesirable, it destroyed the very basis of nursing -

> "Instead of dividing out the patients amongst them, nurses have divided out the work, undertaking a 'round' of this or a 'round' of that .... until every patient appears to the student nurses as an incident in a series of chores. This may be the quickest way of getting the work done, but it is not bedside nursing." (48)

As the last quotation shows this system of division of labour not only had the effect of fragmenting the care which the patient received, it also prevented the student from seeing her work as part of an integrated and meaningful activity, and some people, at least, were beginning to think that any new training proposals must deal with the teaching which was given in the ward as well as with the formal syllabuses.

> "The test should be the extent to which the reoriented training allows the student nurse the deep satisfaction of feeling that she is becoming responsible for the wellbeing of her patients with some degree of continuity and with steadily increasing skill." (49)

It was as an alternative to this kind of task allocation that the Nuffield report put forward the concept of patient allocation, or 'case assignment'. It did this on the basis of having included in the study two small wards in which the nursing was organised in such a way that each nurse, or 'team' of two or three nurses, was concerned with all of the care of some of the patients, rather than some of the care of all of the patients, as happened in the traditional method of 'job allocation' referred to above. It was a concept which was to gain ground during the next two decades, although there is little evidence that it was actually practised to any great extent outside of the intensive care areas, until the much more recent emphasis on 'total patient care' and

'the process of nursing' began to focus attention on the quality of care given to individual patients rather than to groups of patients.

Ward Teaching

Although the job analysis team was not primarily concerned with ward teaching, it did investigate the proposition that teaching was given to the student nurse in the wards during the course of ordinary work done by trained staff and student nurses together. In an analysis of all the time spent by the ward sister and the staff nurses with student nurses it was shown that most of them were in contact with students for any purpose whatever for between 5% and 19% of their time respectively. The inevitable conclusion drawn from this was that

> "even if <u>all</u> the time spent in association with students were devoted to teaching .... only a very small part of their day was being given up to this important function." (50)

Although the actual measurement of the time that trained staff spent in contact with students was new, the problem of lack of ward teaching had been recognised for years. Carter makes it clear that

> "Even the Nightingale School, with its endowment fund, has had difficulty in resisting the claims of the hospital to which it is attached and has been unable to preserve and develop all the clinical forms of teaching which were intended at the time of its inception." (51)

and Seymer quotes Miss Nightingale on the subject,

> "The Sisters do not 'train' or 'instruct'. They have no idea that the probationer is there for anything but to do their work as their Assistant Nurse." (52)

In the intervening years the inadequacy of ward teaching was often given as a reason for the high wastage of student nurses and for the 'poor' quality of nursing care, although it was never specified by which criteria the care was being judged to be poor.

In the absence of any objective attempts to measure the quality of care and in the absence of records of the kind of ward teaching being given or intended, it is impossible now to assess the quality of the ward teaching that took place. In fact, it must have varied enormously from hospital to hospital and even from ward to ward, as these reminiscences of nurses who trained in different Scottish hospitals between 1950 and 1956 show. They were answering questions about how much supervision they received from the ward sister when they were students.

In the following excerpts the respondents words are given in standard type and the questions in italics.

> "She demonstrated for about a week then you started to do them (intra-muscular injections) yourself. She had the same sort of technique for dressings. On the surgical side they told you on the first day what they hoped to do while you were on that ward."

> "I didn't feel in any way critical about my training until after and I was faced with being a staff nurse and then I knew that there had been a whole lot wrong with it. The sisters did not train nurses."

> "There was really very little supervision from the ward sister, and of course it was so ingrained into us that you didn't question anything."

> "I don't remember the ward sister doing much in the way of teaching even at report time. I remember one, but not as a general rule."

> "*So who were your main teachers on the wards?*"

> "I would say probably the senior nurse."

> "*The staff nurse?*"

> "No, the senior student."

"We all went straight to the wards, but the system was very good in that the junior worked with the ward sister."

"*So as a first year student nurse you were working almost exclusively with a qualified nurse?*"

"Oh yes."

In spite of isolated accounts of ward experience that was planned and supervised and of individual ward sisters who did spend a large proportion of their time working with and teaching their student nurses, the only conclusion which can be drawn from this kind of evidence and from what was written at the time is that by and large trained staff, and in particular ward sisters, spent very little time with the nurse in training and that they therefore did very little teaching.

The importance of the example which trained staff give to the students - their function as role models - must not be underestimated, but in order to provide this kind of teaching-by-example the trained staff would have to be visible to the student. In view of the evidence that as a full member of the workforce the learner spent most of her time carrying out a different range of tasks from that of trained staff, and in view of the proportions of trained staff to learners, it is hard to escape the impression that even this kind of teaching was limited, each level of learner modelling herself on the one immediately above her.

Although it was the Nuffield report which had crystallised the concern about ward teaching, that concern had been felt and expressed for a number of years previously. As early as 1943, for example the Nursing Reconstruction Committee had commented

"At present ward sisters are usually so overworked and their wards so understaffed that much of their valuable knowledge is wasted so far as the students are concerned." (53)

Even though those who expressed concern about poor ward teaching were unanimous in maintaining that it was the proper function of the ward sister and that she was the person best fitted for the task, they recognised that it was often not possible for her to do the job adequately. There was no shortage of reasons given for this. Perhaps the most compelling, and certainly the most frequently made complaint, then as now, was that she had no time to teach. Many commentators seemed willing to accept that the ward sister was under pressure without asking what those pressures were or whether they were justifiable, but others did identify a number of specific factors, three of which were summarised in the response of the Scottish Health Services Council to the Nuffield report.

> ".... the Job Analysis confirmed the growing opinion that the training of the student nurse is overwhelmed by staffing needs, by the tendency for ward sisters to be increasingly engaged in the administration of their wards, and by a lack of recognition that while the student nurse is performing tasks in the wards she may in fact be working blindly without understanding of what she is trying to do." (54)

Of these, the shortage of staff and the fact that students were also a major part of the workforce, have already been discussed. Both contributed to the instability of the workforce of which a number of writers complained and which in turn was said to necessitate the system of task allocation which was increasingly criticised after the publication of the Nuffield report (see e.g. 55-57). Other factors which contributed to the pressure on the ward sister, such as the time spent with medical staff and the more rapid turnover of patients were due in part to changing patterns of medical care and bed usage (58). Underlying all of this was the assumption, sometimes openly stated,(59) that the ward sister's first priority was the care of patients rather than the teaching of students. Perhaps

it was that emphasis that gave rise to the claim that some sisters were not interested in teaching and those that were did not have the necessary knowledge or skills to undertake it.(60,61)

However that may be, one result of the priority given to patient care and to the demands of the medical staff, housekeeping duties, ward organisation and clerical duties was that the ward sister was constantly being interrupted -

> ".... in practice in this and many other hospitals where the wards are very large and the turnover very rapid, the ward sisters have only seldom the chance of having a sufficiently long uninterrupted period to enable them to demonstrate thoroughly many of the nursing procedures." (62)

In an early attempt to apply research methods to nursing problems Skellern (63) concluded that it was these constant interruptions combined with the practice of task allocation which reduced the effectiveness of both patient care and ward teaching to unacceptable levels.

The job analysis, then, served to highlight problems which had already been recognised by Miss Nightingale and which continued to bedevil ward teaching, but these problems were not peculiar to ward teaching.

The brief examination of the 'crisis' in nursing in chapter four showed that there was much concern that all was not well in nursing as a whole and that a number of particular problems had been identified in it too. It also showed that there was a failure to recognise these problems as symptoms of a still deeper and more intractable problem - the definition of the proper function of the nurse. Thus the discussion of the perceived problems and of potential 'solutions' tended to be carried on without

reference to the underlying problem. This is illustrated in figure 7 which is intended to emphasise the 'superficial repair' approach which failed to examine the foundation to see if it was sound.

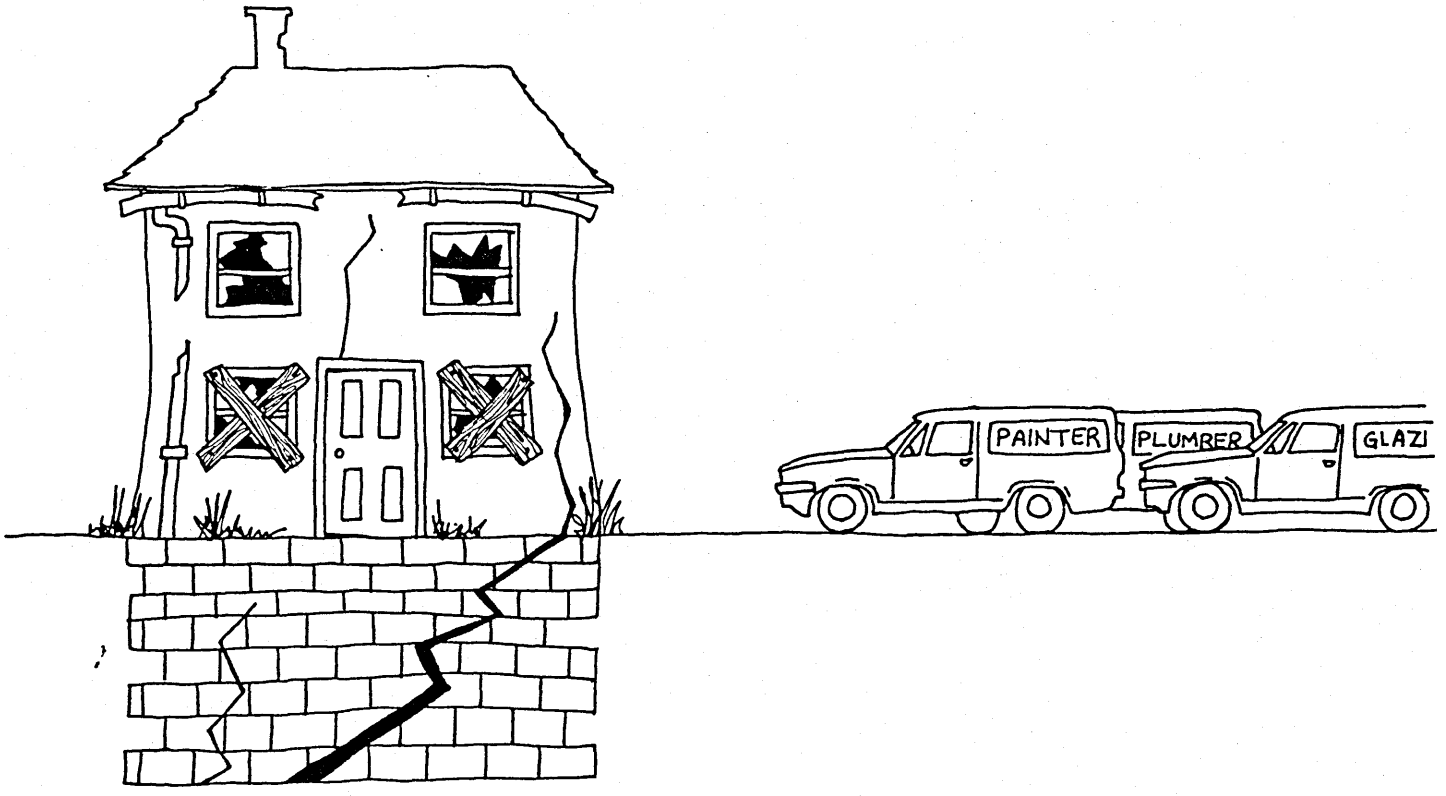


Figure 7 The 'superficial repair' approach to nursing

This failure to identify the fundamental nature of nursing in turn made it difficult, if not impossible, to determine the kind of preparation which would be needed. In nursing education, too there was much dissatisfaction and much discussion of specific problems and their possible solutions but apparently little attempt to identify the nature and purposes of nursing education. To some extent

therefore nurse education can be seen as a reflection in miniature of nursing as a whole, for the problems which were evident in nursing education were of the same kind as those in nursing generally, and the same kind of 'superficial repair' approach can be identified in the ways in which they were discussed. This is illustrated in figure 8.

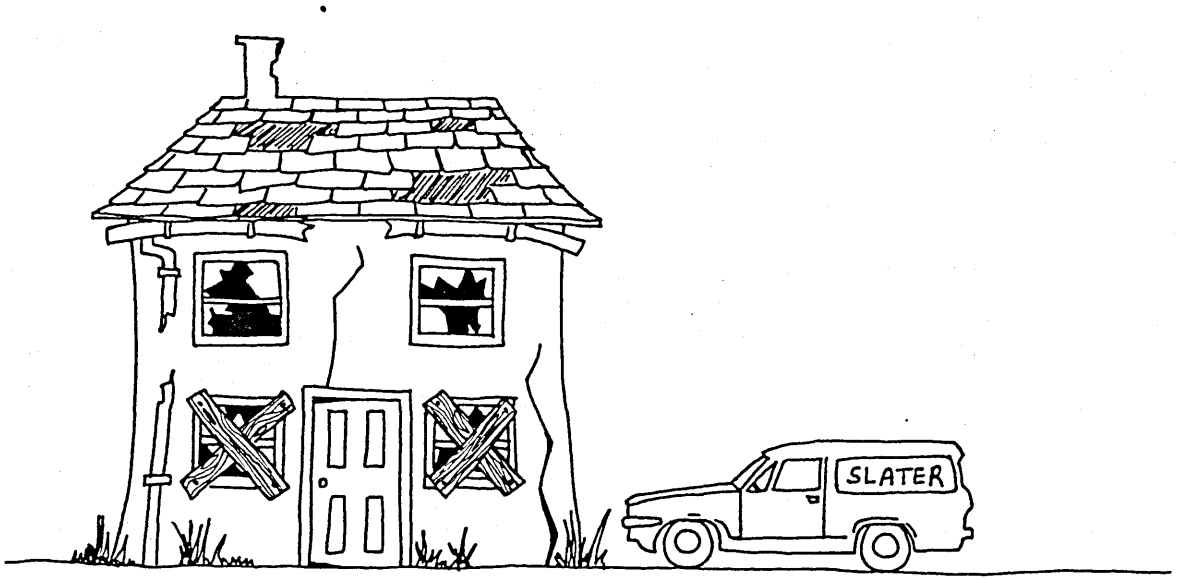


Figure 8 The 'superficial repair' approach to nursing education.

References for chapter five

1. Nightingale F. (1959) Notes on Nursing Duckworth London. 2nd Edition p 15

2. *ibid* p 140

3. Scottish Departmental Committee on the Training of Nurses (1936) Report H.M.S.O. Edinburgh p 13

4. Cope Z. (1955) The Evaluation of the Sister Tutor Nursing Times 51 (9th Dec) pp 1388-1391

5. Ministry of Health, Department of Health for Scotland, G.N.C., G.N.C. for Scotland (1954) The Function, Status and Training of Nurse Tutors H.M.S.O. London

6. Royal College of Nursing (1953) Memorandum on the Nurse Tutor Rcn London

7. Oxford Regional Hospital Board (1956) Training of Nurses in General Hospitals Oxford R.H.B. Oxford

8. Working Party on the Recruitment and Training of Nurses (1946) Report (Wood Committee Report) H.M.S.O. London

9. Royal College of Nursing (1953) *op.cit.* p 5

10. Royal College of Nursing (1956) Observations and Objectives: a statement on nursing policy Rcn London p 9

11. *ibid* p 11

12. Royal College of Nursing (1953) *op.cit.*

13. Ministry of Health, Department of Health for Scotland, G.N.C., G.N.C. for Scotland (1954) *op.cit.*

14. Royal College of Nursing (1953) *op.cit.* p 8

15. *ibid*

16. Nursing Times (1956) Developments and Teaching in the Mental Hospital Field: report of the Rcn Sister Tutor Section conference Nursing Times 52 (13th Jan.) p 37-39 and 44

17. Glasgow Herald (1955) quoted in McQueen, E.U. and McQueen I.A.G. (1956) The Status of Nurse Tutors Nursing Times 52 (7th Dec.) pp 1256-1257.

18. Ministry of Health, Department of Health for Scotland, G.N.C., G.N.C. for Scotland (1954) *op.cit.* p 15

19. Three Qualified Tutors (1959) Letter - Status, Qualifications and Salaries Nursing Times 55 (14th Aug) p 722-723

20. McQueen E.U. and McQueen I.A.G. (1956) The Status of Nurse Tutors Nursing Times 52 (7th Dec) pp 1256-1257

21. Hunt V. (1963) Tutors in the Wards Nursing Times 59 (16th Aug) p 1022

22. Skellern E. (1953) Report of an Investigation carried out "to study, report and make recommendations on the practical application to ward administration of modern methods in the instruction and handling of staff and student nurses" Rcn London

23. The Nursing Reconstruction Committee (1943) Report - II Education and Training (Horder Committee Report) Rcn London

24. Stevens B.J. (1979) Nursing Theory in analysis, application and evaluation Little,Brown & Co. Boston

25. Watkin V. (1956) The Professional Status of Hospital Nurses - 2 Nursing Times 52 (2nd June) p 601.

26. Butcher F.S. (1952) Letter - What should nurses be Taught? Lancet 52:1 (28th June) p 304

27. Nursing Times (1959) The Doctor and the Nurse - Editorial Nursing Times 55 (28th Aug) p 775

28. British Medical Journal (1953) The Duties of a Nurse - Report of a House of Lords Debate British Medical Journal 53:1 (23rd May) pp 1157 and 1172

29. Anderson T. (1953) Letter - The Training of Nurses Lancet 53:1 (23rd May) pp 1047-1048

30. Cropper W. and Houghton R. (1952) Letter - What should a Nurse be Taught? Lancet 52:1 (5th April) pp 716-717

31. Lancet (1955) Time and the Mental Nurse: Report of a job analysis carried out for Manchester Regional Hospital Board Lancet 55:2 (9th July) p 76

32. Godden G.M. (1957) Nursing Education and the Future Nursing Times 53 (8th March) p 153-4

33. Brooke E.B. and Westenhall J.P. (1949) The Economical Use of the Hospital Bed and of the Nurse British Medical Journal 49:1 (19th March) pp 491-493

34. Carter G.B. (1939) A New Deal for Nurses Gollany London

35. Royal College of Nursing (1953) *op.cit.* p 12

36. Ottley L.J. (1952) Letter - What should Nurses be Taught? Lancet 52:1 (19th April) p 821

37. Working Party on the Recruitment and Training of Nurses (1946) *op.cit.* p 12

38. S.E. Metropolitan Area Nurse Training Committee (1957) The Work of Student Nurses and Pupil Assistant Nurses S.E. Metropolitan A.N.T.C. London

39. Lancet (1955) *op.cit.*

40. Oppenheim A.N. (1955) The Function and Training of Mental Nurses 5 Nursing Times 51 (1st April) pp 358-360

41. Carter G.B. (1956) A Study of the Course for Nurse Tutors organised by the Rcn (Scottish Board) Rcn London p 39

42. McNaughton M. (1959) Nursing Service: How to Meet the Demand in General Nursing Nursing Mirror 89 (25th June) pp 205-206

43. Skellern E. (1953) *op.cit.* pp 17-18

44. Royal College of Nursing (1953) *op.cit.* p 5

45. Working Party on the Recruitment and Training of Nurses (1946) *op.cit.* p

46. Nuffield Provincial Hospitals Trust (1953) The Work of Nurses in Hospital Wards: the report of a job analysis Nuffield Provincial Hospitals Trust London

47. Skellern E. (1953) *op.cit.*

48. Lancet (1948) What is Nursing? Leading Article Lancet 48:1 (10th Jan) pp 69-70

49. Lancet (1949) The New Utilitarianism Lancet 49:1 (7th May) pp 792-3

50. Working Party on the Recruitment and Training of Nurses (1946) *op.cit.* p 123

51. Carter (1939) *op.cit.* p 127

52. Seymer L. (1960) Florence Nightingale's Nurses Pitman London p 92

53. The Nursing Reconstruction Committee (1943) *op.cit.* p 20

54. Department of Health for Scotland: Scottish Health Services Council (1955) The Work of Nurses in Hospital Wards H.M.S.O. Edinburgh p 4

55. Nursing Times (1954) Report of Rcn Sister Tutor Section Conference Nursing Times 50 (13th Feb) pp 176-178

56. "P.D.N." (1959) The Leicester Experiment Nursing Times 55 (23rd Oct) pp 1034-1036

57. Nursing Mirror (1960) Whither Nurse Training? Nursing Mirror 110 (1st April) p 41

58. Robertson (1979) The Development of Clinical Teaching Nursing Times 95 (21st June) p 1063-1064

59. Nursing Mirror (1955) Report of Association of Hospital Matron's discussion: Clinical Teaching of Student Nurses Nursing Mirror 100 (20th May)

60. Hemmings J. (1962) Letter - Clinical Instruction of the Student Nurse Nursing Times 58 (25th May) p 666

61. Greene J. (1963) Letter - Clinical Instructors in Mental Hospitals Nursing Times 59 12th July

62. Stopford-Smyth A. (1948) Letter - Clinical Sister Tutors Nursing Times 44 (14th Feb) p 124

63. Skellern E. (1953) *op.cit.*

CHAPTER SIX

CLINICAL TEACHING

As was noted in the last chapter, concern had been expressed about the amount and quality of ward teaching for many years, although the level of concern, at least as it was expressed in the nursing and medical journals, varied considerably, as did the terms in which it was expressed. During the period from 1947 to about 1970 a number of 'waves' of interest can be identified, although much of the material appears to be unconnected and there was much tracing and retracing of the same ground as new contributors addressed themselves to the subject or responded to the comments of others. Over this period the focus of attention moved, albeit in a somewhat circular fashion, from a general concern about the poor quality of ward teaching, through concern about the introduction of clinical teachers, to expressions of clinical teachers' dissatisfaction with their lot and with the way in which their job was being defined. Bearing in mind the state of the nursing journals at the time and the fragmented nature of nursing itself, particularly during the earlier part of this period, it is possible to divide the period into three phases, although their boundaries are not clearly defined and the dates given below should be regarded as rough guides only.

Between 1947 and 1951, that is immediately prior to the publication of the Nuffield report, there were a number of letters and articles recommending or describing the introduction of a new member of staff to teach in the ward. This person is variously described using such titles as 'practical tutor', 'clinical tutor', 'ward instructor', and 'clinical instructor'. In time it was the last of

these which came to be used most commonly and which was given official sanction by the General Nursing Councils until 1968 when the title "clinical teacher" or "clinical nurse teacher" was formally adopted. For the sake of simplicity the phrases "clinical teacher" and "clinical teaching" are used throughout to refer to the person and to his or her activities. While the feminine pronoun continues to be used, it must be borne in mind that although the great majority of the early appointments were women, men were also appointed.

Between 1951 and 1953 ward teaching was supplanted by other concerns and received little public attention, but, following the publication of the Nuffield report in 1953 it once again became a focus for attention.

During 1953 and 1954 the report was summarised and commented on in both British nursing weeklies, and the Nursing Mirror, in particular, did its best to stimulate discussion of the report amongst its readers. Although these efforts prompted few letters to the journals, there were a number of conferences and study days arranged by individual hospitals and associations as well as by the Rcn at which both the report and the problems of ward teaching were discussed. Indeed, from 1953 onwards, ways of improving ward teaching and the 'problem of the clinical teacher' became the subjects of a debate which continued sporadically for the next ten to fifteen years and which has been reopened at intervals ever since.

It is not always possible to identify the authors of letters from these three periods, since many did not indicate their grade and some did not give their names, but much of the later material was written by clinical teachers themselves and at least some of the other authors may have had first hand experience of clinical teaching. It is, therefore, convenient to divide the material into

two parts. One dealing with the first two periods and the early part of the third up to about 1960, by which time a preparatory course for clinical teachers had been established. The other dealing with the rest of the third period from 1960 onwards.

From the earlier material, that is, that dating from approximately 1947 to 1960, a number of controversies can be identified and these are summarised below as a series of questions.

- should the ward sister be relieved of some of her other duties to give her more time for teaching or should she be given help with her teaching or be relieved of the teaching itself?
- if a specialist ward teacher were to be introduced, should that person be a staff nurse or an additional ward sister and what would be her relationship with the regular sisters?
- what is meant by ward teaching and just what would a specialist ward teacher be expected to do?

It should be borne in mind that, although these questions are posed here as a progression from one choice to the next, the stage of thinking about ward teaching which they represent existed simultaneously in different hospitals and in different parts of the country. In seeking to answer these questions it must be stressed that the questions themselves, as they are set out above, were seldom defined clearly in the individual sources, nor were the problems they pose discussed systematically. Rather, each author commented on those aspects of the subject which seemed to her to be of most importance, and often ignored altogether other facets of the topic.

Much of the debate revolved around the question of the kind of help which should be given to the ward sister if the quantity and quality of ward teaching was to be

improved. Three main proposals were put forward, almost always with the implicit or explicit proviso that it was the ward sister who should be responsible for the practical training of the student nurse.

The first of these - that the sister should be given some form of preparation for teaching - was made by several writers (e.g. 1,2) and did not excite either comment or contradiction. The remaining two - providing extra staff to undertake the teaching for the ward sister, and relieving her of some of her other work in order to give her more time to devote to her teaching - were more controversial. The second of these can be seen as a response to the Nuffield job analysis and to the smaller analyses to which that study gave rise, although it may also have been an attempt to find a more acceptable and somewhat belated, alternative to the employment of clinical teachers.

Although Skellern (3) was interested in ward administration rather than teaching, she identified the high level of interruption to which both learner and ward sister were subject and the fragmentation of care which would make learning more difficult and she stressed the need for ward teaching to be more formally organised. She was not the only one to advocate better methods of ward administration and better use of existing staff (4-6), but the solution to the problem of ward teaching was more often sought in the provision of some kind of extra help for the ward sister. The form which it was suggested that help might take varied from additional nursing or teaching staff to assistance with the clerical, domestic or administrative aspects of her work, although no details were given as to how that could be achieved and a number of doubts were expressed about the ward sister's willingness to accept such help. (7,8) In fact, quite independent of

considerations of ward teaching, a number of these ideas were introduced in the nineteen sixties and nineteen seventies as successive reductions in the working week increased the pressure on the nursing staff. When they did come, these domestic, catering, clerical and housekeeping changes raised just the kind of problems in relation to the ward sister's loss of control of the patients' environment and hotel services as had been discussed during the debate over freeing the sister to teach.

By far the most common and controversial suggestion, however, was that some kind of help should be given to relieve the ward sister of, or help her with, her teaching.

Clinical Instructors

In its editorial of the twentieth of September 1947 the Nursing Times described an American system in which a Clinical Instructor - "a qualified nurse, skilled in the practice of nursing, who may or may not have taken further training, particularly in teaching" - was appointed to one or more wards. (9) The advantages of this system were claimed to be that the instructor was able to know both the students and the patients as individuals and would have time for discussions and conferences with each student; she would also be able to help the harassed ward sister in an emergency. A similar suggestion was made by Yates in her entry to a British Medical Association Essay Competition under the title "Suggested Improvements in the Methods of Training Nurses", which was published in the Nursing Mirror during the summer of 1948. (10) According to Yates

> "A sister having had special training for this work, might be responsible for the instruction of staff, leaving the ward sister free for her own routine. One of these sisters could be attached to two or three wards, working in conjunction with the ward sisters,

> and arranging with them the clinical lectures and practical demonstrations for the students."

This idea had already been opposed by Woolcombe (11) on the grounds that the sister and the students would have time to teach and be taught if they were both relieved of domestic duties. This was supported by an anonymous "College member" writing to the Nursing Times the following year who nevertheless advocated that newly qualified staff with an interest in becoming nurse tutors should be used as "student tutors" who would be responsible for "teaching the student nurses their practical work in the wards." (12), a suggestion which Armstrong claimed was impracticable because of the large number of "student tutors" which would be required to cover each shift and ensure that "there is always someone to supervise and teach the student nurse". (13)

While the disagreements inherent in this kind of discussion were being aired in the correspondence columns of the journals, others were seriously considering what was being done elsewhere, notably in North America and Scandinavia. (14,15) While it was recognised that the whole pattern of training in these countries was different from that in the United Kingdom, the idea of having a teacher who was formally part of the school of nursing but who was free to go to the wards with the students was attractive. It was not without its drawbacks, however, as Downer pointed out in a penetrating review of the subject which appears to have passed unnoticed or been disregarded by later writers. She suggested that it should be the ward sister who decided which of her responsibilities to delegate otherwise

> "the more interesting jobs will be undertaken by willing hands and the more humdrum left to the ward sister",

with the result that it would be the clinical instructor

rather than the sister who would come to be regarded as the expert in nursing (16), a view which had also been expressed by Scales with reference to developments at the Metropolitan Hospital.(17) As we shall see, similar doubts were later expressed in relation to tutors, but, nevertheless, the idea of devolving the ward sister's teaching responsibility onto another member of staff appealed to many. It was the extent of that devolvement which caused concern.

The relationship between the clinical teacher and the ward sister

If another member of staff were to be introduced to undertake some of the ward teaching, what would her relationship be to the ward sister? She would be working in the ward with patients who were the sister's responsibility and teaching students and pupils who were part of the sister's staff - in some cases the major part of her staff. Would she be working under the direction of the sister or would she be independent of her? Would she be assisting the ward sister with her teaching or would she be expected to undertake all the teaching in the ward? How much control would the ward sister have over what was taught and when and how it was taught? Would the clinical teacher's 'boss' be the principal tutor or the nursing administrative staff, or even the ward sister? In the hierarchical structure of hospital nursing these were important questions.

In order to understand the implications of these questions for clinical teaching the position of the ward sister needs to be considered in a little more detail, for many of the problems which were anticipated can be seen as an expression of concern about the clinical teacher's access to the ward sister's source of status.

Within nursing there was a clear division between clinical nurses and those in teaching and administration so that the ward sister can be thought of as occupying positions in two status systems - the nursing hierarchy as a whole and the individual ward system which included other staff in addition to nurses.

Within the nursing hierarchy there were staff nurses, enrolled nurses, nurses in training and nursing auxilaries, who were 'junior' to the ward sister and tutors and administrators who were 'senior' to her and to whom she deferred. This formal structure, however, did not comprise a simple chain of command, for, although the ward sisters controlled the work of more junior staff, their own work was not controlled to the same extent or in the same way by senior staff. Indeed a ward sister often enjoyed considerably more prestige than her position in the formal structure suggested.

Dodd (18) has put forward the view that this prestige arose from the ward sister's involvement in patient care and especially from her relationship with medical staff, and she connects this with the control of information and of access to medical staff. She points out that although senior staff might seem to be in a position to challenge the ward sister, their contact with patients was usually limited and was mediated by the ward sister who could circumvent that challenge by witholding information and excluding senior staff from contact with medical staff, at least with respect to patient care.

Within her own ward the sister occupied the key position and wielded considerable authority, not only over nursing staff and patients but also over junior doctors and paramedical staff. That authority was both formal and informal. Formally she was responsible to the consultants and the matron for the management of the ward,

the care of the patients and the co-ordination of other services as they impinged on the patients and their environment. She was also accountable for the actions of her staff who in turn were responsible to her alone and to whom were given only as much information and authority as she chose. (18,19)

The work of the nursing staff impinged on that of medical and other staff in two ways. In the first place there were a number of duties which were medically derived although still clearly nursing duties. That is to say they arose directly from the medical conditions of patients and the medical and paramedical interventions which were prescribed for them. However, the boundaries between these nursing duties and those which properly belonged to medical or other staff were not clear cut and there was scope for considerable negotiation in deciding how much help the nursing staff would give to junior medical staff. Secondly, the nursing staff, and the ward sister in particular, could make the work of the medical staff including that of the consultants, more pleasant or more difficult by the way in which the ward was managed. In addition to these sources of informal authority, the sister's authority could be greatly affected by her length of experience and her expertise and by the extent of the consultant's confidence in and reliance on her. (18) In this context, the way in which clinical teaching would be organised and the lines of responsibility which would be established were of considerable importance to the ward sister.

In the main, concern about the relationship between the ward sister and the clinical teacher took two forms. In the first place there were those who were convinced that the clinical teacher would be "one too many in the teaching team of medical staff, tutors and ward sisters" (20).

Such an appointment, it was felt would "affront" both sisters and tutors and some other solution to the problem should be sought. (21-23) Secondly there was a debate as to whether the clinical teacher should be drawn from the ranks of staff nurse or sisters, and more will be said about this shortly. (page 153)

Early Appointments

Meanwhile some hospitals were beginning to appoint specialist clinical instructors, and during 1949 and 1950 the journals carried accounts of experimental appointments at the Royal Devon and Exeter Hospital, the Metropolitan Hospital and St. Luke's and Royal Surrey County Hospital. (24-27) Although these reports prompted little comment in the nursing press at the time, it is perhaps, an indication of the anxiety generated by them and by other similar new appointments that reference was made to "the problem of the clinical teacher" at an Rcn Tutors' Conference early in 1951 (28). As has so often happened in nursing before and since, the new grade seems to have been established almost by default as individual hospitals created posts to suit their own needs. Because these posts were tailored very specifically to meet local needs, the pattern varied from hospital to hospital, as did their titles. Opinion was strong that the clinical teacher should be employed as a member of the teaching staff (e.g. 29,30) and in many cases funding for the new posts was sought through the Area Nurse Training Committee. However, in some cases they were under the jurisdiction of 'Matron's office' and might have administrative as well as teaching duties, while occasionally a second 'teaching' sister might be appointed to a ward.

In 1955 officialdom, in the form of the Department of Health for Scotland, put its seal of approval on clinical teaching and attempted to define it when a sub-committee of the Nursing and Midwifery Advisory Committee, which had been convened to consider the Nuffield report, made its recommendations. This report, which will be referred to as "the 1955 report", contained a number of proposals intended to improve nurse training. The most influential of these were that a shortened form of training, in which the students' experience in the wards would be carefully controlled, should be introduced and that

> "a grade should be introduced in the nursing service to be known as clinical instructors who would be reponsible for teaching student nurses while they were working in the wards." (31)

The following year a scheme, known officially as 'the experimental nurse training at Glasgow Royal Infirmary' and colloquially as the 'Glasgow experiment', was introduced in which two clinical instructors were employed on the staff of the experimental school. As the Assessment Committee reported

> "The employment of such personnel was not entirely new, but this was the first time that the instructors were able to supervise carefully the work of a small number of students throughout their course." (32)

The use of clinical instructors in the experimental scheme created a great deal of interest and was to add another dimension to the controversies of the nineteen sixties but in the meantime the Scottish Board of the Royal College of Nursing initiated discussions with the General Nursing Council for Scotland and the Department of Health for Scotland with a view to offering a course for the preparation and training of clinical instructors.

The first course started in the autumn of 1958 with fifteen students and the Scottish Board continued to offer a course annually until 1976 when the Rcn closed its Scottish Institute of Advanced Nursing Education.

Although the numbers of students taking the Scottish course rose fairly rapidly, it could only cater for a small proportion of the increasing number of nurses who were being appointed to clinical teaching posts. As the Nursing Times complained, by 1961

> "Clinical instructors who have had no formal training in bedside teaching are being used all over the country in increasing numbers." (33)

However, it was not long before other centres followed that lead and by 1976 fourteen centres in the United Kingdom were offering the Rcn course while one had replaced that course with its own college diploma. In addition the English General Nursing Council (though not the Scottish) recognised the courses leading to a Teacher's Certificate of the City and Guilds as being an appropriate preparation for clinical teachers, and both Councils recognised the clinical teaching option of the University of London's Diploma in Nursing.

Type of Course	No of centres offering the course	No of courses of that type available
Rcn syllabus	11	1
Diploma in Nursing	2	2
City & Guilds Teacher's Certificate	not known	3

Table 1 Clinical teaching preparatory courses available in 1976.

The Rcn stipulated that candidates for its clinical instructors' course should be experienced ward sisters of at least two years standing and this requirement had the support of the General Nursing Council for Scotland. In this they were following the practice of many of the hospitals which had already established clinical teaching posts. However, the 1955 report implies that while clinical teaching posts should be at ward sister level clinical teachers might come to them from staff nurse posts for it specifies that they should have "spent at least two or three years as a staff nurse" with no mention of having had experience as a ward sister, and goes on to suggest that, after some time in the post, the clinical teacher would decide whether she wanted to become a tutor or "take a ward sister post". However the exact meaning of this phrase is somewhat uncertain since the next sentence speaks of their "return" to ward sister posts. (34) For both the ward sister and the clinical teacher the point was an important one and stimulated a great deal of discussion in the journals during the nineteen sixties. There were four main arguments against requiring that the clinical teacher should have had ward sister experience.

In the first place it was argued that the staff nurse was the person who was actually doing most of the ward teaching and it would be better to accept this fact and give her some preparation for the task. (e.g. 35,36) Opinion was divided as to whether or not this would make the employment of a specialist teacher unnecessary (35) or whether the specialist teacher should be employed, as Bennett suggested, as a 'teaching staff nurse'. (36-38) Those who disagreed with Bennett's stance did so on the grounds that staff nurses themselves were still learning and therefore not in a position to provide the kind of help and support which students would need, (37-40) and that since "one teaches in the light of one's own

experience" (41), it was essential that "candidates have good and wide experience as ward sisters" (40). Those who argued in this way seemed to be assuming that staff nurses were unlikely to have sufficient experience. Without further information about the length of time which nurses spent in the staff nurse grade and in individual posts it is not possible to judge whether or not that assumption was justified but it does not appear to have been challenged, or even been made explicit at the time.

The second argument against the use of experienced ward sisters was that the experience that a ward sister had was of ward management rather than of nursing care, and that that experience, therefore, was of limited value for the clinical teacher. (42) Clinical teachers themselves disagreed, claiming that experience as a ward sister was essential if they were to work in partnership with the ward sister in planning and organising ward teaching programmes. (e.g. 43,44)

Thirdly, it was suggested that ward sisters who became clinical teachers might feel that they had "lost something by not having full charge of the patients' care" (45). It is interesting in view of the concern about the status of the clinical teacher, that Morgan, who was tutor to the Glasgow Experiment, could argue strongly that the clinical teacher should have had ward sister experience, apparently to establish her credibility as a nurse, "The clinical instructor should have had a ward sister's experience. She should be known and respected .... for her ability as a practical nurse." Yet in the same paper she asserts that "everything to do with patients and student nurses must be referred to the ward sister or staff nurse" because "student nurses are under the direction of the ward sister and consequently the clinical instructor is also under her direction" (46).

Confusion over what was meant by "being under the direction" of the ward sister and the conflict created by the discrepancy between past responsibility and present experience helped to create a crisis of identity for the clinical teacher.

Finally, it was felt that if the clinical teacher was an experienced ward sister she might "put a junior sister at a disadvantage." (45) This last point, however, was only a more extreme expression of the view that introducing clinical teachers to the wards would in any case undermine the position of the ward sister, which goes a long way towards providing an explanation of the hostility and suspicion with which the introduction of clinical teachers was often regarded, and their own preoccupation with their grading and status *vis à vis* both the ward sister and the tutor.

As indicated earlier, it is not always possible to identify the individuals who wrote to the journals, or the positions which they held. Neither is it always possible to tell from their letters and articles whether they were merely speculating about the possible effects of employing clinical teachers or whether they had first hand experience of them, although it is interesting to note that in most cases where the writer, ward sister or tutor, does claim first hand knowledge the comment is fairly positive.

The Content of Clinical Teaching

Although everyone was agreed that there was insufficient teaching being done in the wards, it is evident from the little that is said about what the students needed and from the various descriptions of what a clinical teacher's remit ought to be, that there were different opinions as to the kind of teaching which was required as well as the way in which it should be organised.

The reports of the early clinical teaching appointments referred to above indicate that these clinical teachers were sisters who were expected to "supervise, demonstrate, and explain procedures" (47) and to help and advise students. Although they sometimes worked with groups of learners, most of their time was spent working with individuals. While their responsibility *vis à vis* the ward sisters was not clearly identified, there is an implication that they were relieving the ward sister of some of her teaching and that they were in some respects subordinate to her. (48) The 1955 report changed the emphasis somewhat by recommending that the clinical teacher should be regarded as an extension of the tutor. It stresses that this is "in no way an attempt to derogate from the position of the ward sister" and recommends that the clinical teacher should be of "ward sister level" with several years of experience as a staff nurse. There is no mention of experience as a ward sister. It suggests that she should teach in several wards and that although her responsibility would be primarily to the teaching department, her work would be controlled by the ward sister because she would be teaching student nurses the "nursing techniques involved in the cases to which they had already been assigned by the ward sister". Although this is not made explicit in the report, it is implied that this would be a temporary appointment and perhaps a training grade, since "it seems likely that most of them would return to sister posts." (49) Despite the report's careful emphasis on the clinical teacher's responsibility to the teaching department and the need for co-operation with the ward sister, the Chief Nursing Officer of the Department of Health for Scotland, in a speech in which she describes the clinical instructor as a "new grade of senior nurse" whose duty is to "supervise, instruct and help the student nurse in practical procedures at the bedside",

is reported as saying that "she (the clinical instructor) is, of course, responsible to the ward sister" (50); a comment which appears to have gone unnoticed by clinical teachers!

By 1965 the concept of "practical instruction" which would "supplement" that given by the ward staff had been enshrined in a Nurses and Midwives Whitley Council circular. (51) This was widened slightly by the Prices and Incomes Board three years later to include co-ordination of experience (52). In the meantime, the committee on senior nursing staff structure had recommended that clinical teaching should be regarded as

> "posts in which nurses test their aptitude for teaching before going on to become Registered Tutors." (53)

Most of the comment which touches on this subject deals with the kind of teaching activity which could be expected of clinical teachers rather than the kind of help which the student might need, presumably because it was written in the context of the controversy over the employment of clinical teachers rather than of the value of clinical experience to the student. Although identification is not always possible, very few students seem to have contributed to the debate, and it is therefore worth referring specifically to the views of those who did. In September 1959 a student commented in a letter to the Nursing Times that ward teaching was impractical because "routine duties cannot be interrupted indefinitely nor arranged to suit the teaching staff" (54). This was immediately refuted by McPherson and Brooks who claimed that "co-operation between the ward sister and the clinical instructor ensures that the practical demonstrations are part of the nursing care of the patient and thus the ward routine is not interrupted" (55). Although the emphasis

is still on procedures, a first year student writing several years later (56) agrees with these writers when they go on to suggest that the clinical teacher would not only demonstrate procedures, she would also give them guidance and support as they worked with patients. This suggestion is confirmed by a Nursing Times report of a debate at a meeting of the Student Nurses Association Central Representative Council -

> "... Council were in no doubt of the value of this method of ward teaching. It was felt that clinical instructors could avoid much of the trauma often created by carrying out new procedures and that both students and patients would benefit." (57)

From these references and from other writers who tried to speak for students, three kinds of help which students might need can be identified - the demonstration and supervision of nursing procedures and treatments, the correlation of theory and practice through teaching related to the whole care of patients, and support, guidance and counselling. There were, however, very different views expressed about the extent to which a clinical teacher rather than a ward sister could or should give each of these kinds of help. This suggests that there was a variety of opinion as to just what constituted clinical teaching and about the remit which should be given to clinical teachers. Although a number of papers and letters refer to that remit and describe what clinical teachers were doing or what the authors thought they should be doing, there seems to have been no clear policy or definitive description of clinical teaching issued by either of the General Nursing Councils until the early nineteen sixties. For example, even when the Scottish Council gave permission for the Rcn to offer a preparatory course in 1958, it accepted the Rcn's recommendations on a 'wait and see what develops' basis rather than providing any clear policy or framework for

the employment of clinical teachers. The record of the negotiations between these two bodies as it is obtained from the minutes of the Rcn Scottish Board's education committee and the GNC's committee and council meetings is tantalising in its brevity, for decisions are recorded with little or no detail of how they were reached or of any discussion of the implications of these decisions. Care must be taken not to assume too readily that the absence of record necessarily means that no such discussion took place or that members of Council were not aware of the possible implications of the introduction of clinical teachers, but the leading part which was played by the Rcn (which must be seen as an interested party) in creating a separate identity for clinical teachers and the piecemeal way in which posts appear to have been created does suggest that, as has happened so often in nursing before and since, what was thought of as a temporary expedient became a permanent arrangement almost by default. In this connection it is interesting to note that two of the members of the committee which produced the 1955 report were also members of Council and one of them was the Rcn's Scottish education officer.

In its annual report for 1962-63 the General Nursing Council for England and Wales expressed its anxiety "to increase the amount of bedside teaching and supervision of student nurses throughout their training" and its hope that "the clinical instructor would assist both the ward sister and the tutor in these matters." (58) Just what bedside teaching and supervision might entail, however, was a matter of some debate. Although it was assumed that the tutor would not confine herself to the classroom but would also undertake some 'teaching in the ward' the ward sister was expected to be responsible for the 'ward teaching' given to the student while she was in

her ward. Whether the difference in wording is significant or accidental is not clear, though it appeared in letters and papers throughout this period, and there is at least some evidence that many writers regarded such teaching as the tutor might do in the ward more as an extension of her classroom teaching than as 'true' ward teaching. (e.g. 59,60)

An Ideal Model?

Although some of the material discussed above was written by people who had had first hand experience of the early experimental clinical teaching appointments, much of it consists of letters and papers which are speculative rather than factual and of recommendations contained in official reports. The picture of clinical teaching which emerges from this material can therefore be described as prescriptive rather than descriptive.

This picture is of a staff nurse who, having had two or three years' experience, is interested in teaching but reluctant to become a tutor. For her, appointment as a clinical teacher would be promotion since the post would be graded at ward sister level for salary purposes, and indeed it seems to have been expected, at least by some, that the post would be a transitional one, with the clinical teacher moving into a ward sister's post, or perhaps becoming a tutor, after a few years of clinical teaching.

After a short preparatory course, the new clinical teacher would join the staff of the school of nursing where she would work under the direction of the principal teacher. However, although she would be a member of the staff of the training school her work would be mainly in the wards where she would assist the ward sisters with the teaching of student and pupil nurses. Just what that

might mean in terms of day to day activities is unclear, but, since the clinical teacher was to be allocated to several wards, it would include visiting each ward to discuss her contribution to the day's work with each of the ward sisters. Some tentative questions were asked about whether it would be appropriate for the clinical teacher to visit each of her wards every day or to spend a longer period, perhaps a whole day or a week, in each in turn, but there seems to have been no attempt to identify the implication for the clinical teacher or the ward sister, or for that matter the learners, of either of these patterns. It was expected however that the clinical teacher would demonstrate nursing procedures which were new to the students in the wards and supervise them as they learnt to carry out those procedures.

Although she was not to be responsible to the ward sisters in the sense that she did not form part of the ward staff, it was expected that the clinical teacher would work under their direction while she was in their wards. As we have seen the Nuffield report showed that ward sisters on the whole spent very little time with learners and that perhaps leant weight to the expectation that clinical teachers would 'supplement' their teaching, both by undertaking the necessary demonstration and supervision of practical procedures for her, thereby freeing the ward sister to do other things, and by providing extra support and instruction for the learners when the ward sister's other commitments prevented her being with the learner.

From this group of writings, then, <u>a prescription or 'ideal model' of clinical teaching</u> can be derived which is summarised as follows -

> The clinical teacher would be an experienced staff nurse, who would not necessarily have had ward sister experience, employed to assist the ward sister in the teaching of practical skills and procedures. This would be a temporary appointment from which the clinical teacher would either return to 'service', presumably as a ward sister, or become a fully fledged tutor. For salary purposes the clinical teacher would be graded as a ward sister and she would have a short preparatory course dealing with teaching methods.

Clinical teachers themselves took exception to some of these pronouncements, claiming that, at best, they showed little understanding of the job, and at worst they were totally misleading. (e.g. 61,62) They were concerned about the way in which the job was evolving and, during the nineteen sixties, made a number of attempts to identify what they were actually doing and to analyse the problems which they were meeting in attempting to follow their own prescriptions. At the same time the development of a formal preparatory course helped to crystallise thinking about clinical teaching and its effects must be considered before turning to the experience of the clinical teachers themselves.

Preparatory Courses

The 1955 Report, in recommending the employment of clinical teachers, had suggested that they should take "a short course - say six weeks - in teaching methods." (63) and this suggestion was taken up and developed by the Scottish Board of the Rcn whose education officer had been a member of the committee. She drew up a memorandum for the Board's Education Committee which subsequently provided the basis of discussions first with the Rcn's Council and then with the General Nursing Council for Scotland and the Scottish Home and Health Department.

At this time the Rcn was already offering a three month ward sisters' course which emphasised the ward sister's three functions of expert nurse, ward administrator and bedside teacher, but the Scottish Board felt that if the clinical teacher was to become the link between the teaching staff of the school of nursing and the sisters who were responsible for the learners in the wards, something more than this would be needed. By the summer of 1957 the Rcn Council had agreed that the Scottish Board should organise an experimental course of six months duration and an outline of the proposed course had been drawn up. This opened the way for discussions with the G.N.C.'s training and registration committee at which the Rcn representatives justified their proposals on the grounds that the course should be preparing clinical teachers to use a 'situation-centred' approach to teaching which would incorporate 'the scientific and sociological principles which underlie nursing skills' rather than merely handing on the skills themselves. From the beginning the Scottish Board had insisted that it was essential for the clinical teacher to have had experience as a ward sister and there seems to have been some expectation that the employment of clinical teachers would go some way towards compensating for the shortage of tutors, although both in the memorandum and in correspondence, first with the General Nursing Council and later with the Department of Health for Scotland, it was stressed that they should not in any way either replace the tutors or duplicate the functions of the ward sisters. By the following summer it had been agreed that the Council would support the development of the new grade on condition that they were employed to teach in the field in which they were registered as nurses and that the Department of Health would provide monies for secondment to the course through the Regional Nurse Training Committees.

The first course, lasting six months, started in October 1958 with eight students, all of whom were Registered General Nurses. Its aims were to help the students to -

"1 become better acquainted with the role of the clinical instructor
2 define the role of the clinical instructor;
3 increase both knowledge and understanding of the unique contribution of the qualified nurse to society;
4 develop a questioning attitude towards present practice in nursing;
5 become better acquainted with the modern concept of supervision, its principles and techniques;
6 become better acquainted with methods of imparting information in face-to-face situations;
7 become better acquainted with the current problems in nursing and methods of dealing with them;
8 become better acquainted with the literature which helps in dealing with problems." (64)

It included group work as well as formal lectures on applied physiology, general science, psychology, history of nursing and the development of the profession, the structure of society, medical therapeutics and nutrition, and the principles and practice of teaching.

The evaluation of any course can be difficult since there are many criteria which could be used and different perspectives which will give different results. For example, participants may have a different perspective and different criteria from those of employers and there are short term considerations such as 'enjoyment' and the organisation and management of the course including the weighting of subjects in the timetable, and longer term considerations of the relevance of the course to the job to be done and to personal and professional development. It is the last of these - the longer term value of the course, whether to the participants or to the employers, - which poses the most difficulty and which can be evaluated

least effectively, at least until participants have been 'back in the field' for a time and probably until some experience has been built up and any initial problems relating to course organisation and management resolved. The evaluation of this first clinical teachers course was closely related to 'the problem of the clinical teacher' as a whole and had to be considered in the light of the discussions about the introduction of this new grade and the remit which should be given to clinical teachers. Short of a reversal of policy, therefore, it was almost inevitable that the first course would be followed by others while some attempt was made to evaluate what was being done.

In January 1960 the General Nursing Council's registration and training committee considered a report of the first course and at that meeting the whole question of who was the best person to undertake the ward teaching was again raised. Clearly some members of the committee were uneasy about the development of a separate grade of clinical teacher and expressed particular concern about the possibility that ward sisters might be able to do more teaching themselves if their work was organised differently; the possibility that in view of the shortage of tutors the introduction of clinical teachers might do nursing a disservice by engendering a false sense of security about nurse training, the position of the clinical teacher *vis à vis* the ward sister and the tutor; the relationship between the clinical teachers' course and the ward sisters' course which was already in existence.

Although these matters were also discussed both by the whole Council and at meetings with representatives of the Rcn Scottish Board and the Department of Health for Scotland, no conclusions about them are recorded.

Nevertheless, a change of emphasis can be identified in later meetings away from the questions identified above and towards determining the numbers of clinical teachers which might be required, the length of clinical experience which should be obtained prior to taking the course, and the possibility of registration. It might be thought that the fact that this kind of question was being discussed suggests a commitment to the concept of the specialist clinical teacher, but this does not seem to have been the case, for, although, Council accepted the recommendation that the course should continue, that agreement was couched in terms of extending an experiment until such time as hospitals employing clinical teachers would report on their experiences. However, in spite of appearing to want to wait and assess developments before committing itself to this kind of clinical teaching, the Council did explore the possibility of offering successful students of the course certificates of registration as a teacher of nurses under the provisions of the 1951 Nurses (Scotland) Act. By 1962 the necessary Rules had been approved by the Secretary of State and Registration as a Clinical Instructor became available to acceptable candidates who had completed an approved course, thereby continuing the process of formalising the existence of the new grade which the provision of a recognised preparatory course had begun.

The existence of a formal preparatory course helped to create a sense of separate identity amongst clinical teachers, an effect which they fostered by forming a number of associations such as the League of Edinburgh Trained Clinical Instructors. It also helped to crystallise thinking about clinical teaching both because clinical teachers now had a separate identity and also because the course itself attempted to deal with clinical teaching in a formal way as part of the curriculum. It is appropriate

therefore to consider the way in which the course defined clinical teaching before examining the writings of clinical teachers themselves.

In trying to identify the ways in which clinical teaching was defined by the course, three kinds of material have been considered - the formal curriculum, the writings and comments of the course organisers and the writings and comments of students. It is clear from these that during the first two or three years there was a gradual change of emphasis from 'procedure-centred' to 'patient-centred' teaching. There can be little doubt, in view of the fact that visits to Glasgow Royal Infirmary were a formal part of the first few courses, that the 'course view' was influenced by the pattern of clinical teaching developed there. A clinical teacher had already been in post at Glasgow Royal Infirmary for eighteen months prior to the start of the experimental scheme of training in 1956. She had mainly been concerned with learners who visited the wards for one day a week while they were in the preliminary training school and during their first ward allocation thereafter, demonstrating and supervising those aspects of nursing care which were associated with nursing procedures. With the introduction of the experimental scheme two more clinical teachers were appointed to work with students of the scheme at all stages of their training. They also conducted tutorials and discussions dealing with aspects of the care they were demonstrating and supervising.

When the course for clinical teachers was started the curriculum included lectures and tutorials dealing with such topics as the handling of small groups of learners and the promotion of active learning as well as the demonstration and supervision of nursing procedures, and, during the second term, one morning each week was devoted to teaching practice. This took the form of role

play, one student taking the part of the patient, one of the nurse learner and one of the clinical teacher. Particular attention was paid to the way in which the potential clinical teacher presented the materials and her rapport with the 'student' and approach to the 'patient' in these sessions. (65)

The view of clinical teaching which was advocated during the course was that it should enable the learner to 'correlate theory with practice'. To this end the clinical teacher was expected to demonstrate and supervise the nursing care that was being given by the learners and to discuss it with them, either individually or in groups. It was stressed that the care that was used as the basis for teaching was the normal care required by patients and that teaching opportunities should be used as they arose and not be created, either by subjecting patients to unnecessary procedures or by divorcing tutorial topics from the care which the learners were actually giving. In order to do this, the clinical teacher would have to know the patients in the ward and their treatment, as well as the learners, and she would need to develop a relationship with the ward sister which allowed her easy access to information and the freedom to decide which learners she would work with, and how she would spend her time.

Co-operation with the ward sisters was considered to be of paramount importance but there was no question of the clinical teacher being subordinate to them. She was expected to be a member of the teaching staff with equal standing to that of a nurse tutor. She was also expected to have a limited number of wards in her allocation in order for her to maintain her familiarity with the day to day care and progress of the patients. She was not

expected to take part in 'classroom activities'. Her attention was to be given to learners while they were in the wards and it was suggested that she should be readily available to them not only because of her limited allocation of wards but also because she should have an office near to those wards.

Although this was the picture of clinical teaching which was put forward during the course some aspects of it, for example the number of wards in an allocation and the siting of offices, were presented as the ideal towards which to work rather than as the generally accepted norm. Other aspects were somewhat ambiguous. For example, the need both to plan teaching carefully and to seize the 'teachable moment' as it arose was stressed, but there seems to have been little attention paid to ways of reconciling these two activities or of analysing the constraints imposed by the nature of the clinical areas.

The clinical teachers' course then provided a second 'prescription' which was amplified by the clinical teachers themselves.

> Clinical teachers should be experienced ward sisters who, in co-operation with the ward staff, provide the students with regular, planned teaching by working with them in the wards. This teaching should include the demonstration, supervision and explanation of practical nursing procedures and skills and the explanation and discussion of the treatment of individual patients, and should bring together the tutor's teaching in the classroom, the doctor's lectures and the care which the students are seeing and giving every day. Clinical teachers should also act as guides and counsellors to staff, including staff nurses.

Having identified not one but two historically derived prescriptions for clinical teaching, it is timely, before going on to consider the extent to which either of them is reflected in subsequent developments in clinical

teaching or the writings of clinical teachers, to review the historical data in the light of the concepts and categories generated from the exploratory work described on page 47.

When these data are ordered they fall into several categories which are similar to those derived from the preliminary study -

1. organisation of clinical teaching
   - based in ward not the classroom?
   - office near the wards?
   - allocated to two or three wards only?
   - responsible to teaching department? matron's office?
   - teaching in own specialty only
   - visiting every ward every day? spending half days in a ward at a time?
   - first year only or all levels?
   - individuals or groups?

2. implementation of clinical teaching
   - type of teaching - supervise, demonstrate, explain procedures
     - clinical demonstrations
     - procedure centred
     - advise, support guide students while working with patients
     - clinical lectures and discussions
     - patient centred
   - planning - ward sister allocates work to learner and discusses this with the clinical teacher
     - discuss with ward sister
     - seize the teachable moment
     - plan ahead
   - relationship with ward sister - relieve her of all teaching?
     - help her with her teaching?
     - subordinate to?
     - co-operate with?
     - controlled by?
     - undermine the position of?

3. career development

past experience - length? staff nurse or ward sister?
clinical teaching seen as transitional? relatively permanent?
destination (next post) - ward sister? tutor?
status - teaching staff nurse? second sister? specialist teacher? tutor?

Many of the items in the categories are presented as questions or are contradictory. When these problematical items are rewritten to show a comparison between the two prescriptions it becomes clear that choosing to follow one of these prescriptions rather than the other would result in very different patterns of development.

	first prescription	second prescription
Career development		
past experience	staff nurse	ward sister
clinical teaching seen as	transitional	? permanent
next post	ward sister/tutor	-
grade	ward sister	? tutor equivalent
Implementation of clinical teaching		
type of teaching	procedure centred	patient centred
	supervise, demonstrate, explain procedures	advise, support, guide students while working with patients
	clinical demonstrations	clinical lectures and discussions
planning	not mentioned	stressed
relationship with ward sister		
	ward sister takes the lead	clinical teacher autonomous
	helps sister with teaching	teaching is different from, complementary to that of ward sister
	sister ? directs, ? controls	co-operates with sister
	? undermines position of ward sister	stimulates ward staff to teach more
learners	nurses in training ? mainly first year	nurses in training at all levels, newly qualified staff.

To some extent, these two prescriptions reflect the evolution in the way in which nursing itself was being conceptualised and organised, which was to become apparent during the nineteen seventies and nineteen eighties. Inherent in the first prescription, with its emphasis on the pivotal position of the ward sister and a task oriented routinised performance, is the idea of assistance. The new member of staff, whatever title she might be given, was there to help the ward sister with her teaching, not to undertake teaching on her own account. True, some concern was expressed that the clinical teacher might be used, inappropriately, to assist the tutor, but on the whole it was the ward sister's teaching that she was expected to supplement not the tutor's. It is for this reason that so much concern was expressed about the clinical teacher's relationship with the ward sister while her relationship with the tutor is hardly mentioned until after clinical teaching appointments had become much more numerous.

The second prescription eschews the idea of assistance and claims a much more independent and identifiable role for the clinical teacher. The idea that a nurse could work in the ward without being subordinate to the ward sister, or formally part of her staff, provides an early indication of the way in which the whole structure of nursing was to change; just as the emphasis that the clinical teacher should not be confined to the teaching of procedures but should be concerned with the whole care of the patient, reflects the modern emphasis on 'total patient care'.

It would be interesting to speculate on the extent to which clinical teachers who adopted the second prescription were influential in bringing about these

changes, but that is outside the scope of this study. What must now be considered is the extent to which either of the prescriptions was followed in the way in which clinical teaching developed after the introduction of preparatory courses.

Which Prescription?

Increasingly, from the mid-nineteen fifties onwards, clinical teachers themselves contributed to the debate. It is evident from the tone of their writing that they felt themselves to be both disadvantaged and misunderstood.

The material now to be considered is of three kinds:

- letters and articles from individuals, whether clinical teachers, ward sisters or tutors, describing their own experience of clinical teaching;
- the responses of clinical teachers to what was being said or written about clinical teaching and the way in which it was being graded for salary purposes;
- reports of formal or semi-formal attempts, by clinical teachers, tutors to the preparatory courses and others, to identify and, evaluate what was happening.

Grading and status

From the papers already referred to it is evident that the early clinical teachers were ward sisters who did not change their grading when they were appointed as clinical teachers. This precedent was followed in later appointments and clinical teachers continued to be graded as ward sisters for salary purposes. When the Rcn introduced its preparatory course in 1958 it required candidates to be experienced nurses with at least two years ward sister experience and it was not long before these clinical teachers began to look for a new salary scale. However, salaries for nurses were negotiated on

a United Kingdom basis and the position of clinical teachers in England and Wales was somewhat different from those in Scotland.

Whether the Rcn's insistance on ward sister experience originated with the Rcn itself or with the General Nursing Council for Scotland is not clear, but there is no doubt that these two bodies were in agreement about its necessity. Their recommendation was accepted by the Secretary of State for Scotland, both when he agreed that the GNC should pay the fees of Scottish students of the course and when he approved the Rules providing for the registration of successful students. In England no such agreement between the General Nursing Council and the Ministry of Health existed. There, in 1965, the King's Fund Staff College started to offer a three month residential course for prospective clinical teachers. (66) The Rcn, and Rcn-trained clinical teachers, criticised this course on the grounds that it was only half the length of the Scottish course and could not therefore cover the same ground, and also that it accepted staff nurses. (67) The first of these criticisms was answered by pointing out that in a residential course more material could be covered than in a non-residential one and that in any case the course was intended to follow the three month ward sisters' course and could therefore be seen as the second part of a two stage course.

The second criticism represents a fundamental difference in thinking from that of the Rcn and is in line with the first of the prescriptions identified earlier, rather than the second. It was of considerable importance in the light of later recommendations of the Whitley Council (68) and the Committee on senior nursing staff structure (69). It also had repercussions on the attempts to secure registration of clinical teachers in England and Wales.

As we have seen, the registration of clinical teachers by the General Nursing Council for Scotland became effective in 1962. The English Council was also empowered to offer certificates of registration as a teacher of nurses under the 1951 Nurses Act. However, while the Acts identified the parameters within which the Councils could work, it was the Rules which set the ways in which the provisions of the Acts would be implemented. Any alteration in the Rules, such as would be required to extend registration to clinical teachers, had to be effected by a Statutory Instrument which required the signature of the appropriate minister. In England and Wales the battle to gain registration on the same basis as was accepted in Scotland was a long drawn out one. There the Minister refused to recognise clinical teaching as a new development or to approve the General Nursing Council's proposals for registration unless clinical teaching was opened to staff nurses on completion of basic training, and unless the Council was prepared to consider the possibility of a part time preparatory course. (70) The Council, however, took the view that ward sister's experience was necessary for a clinical teacher and it was not until 1968 that it reluctantly agreed to the Minister's conditions. In the interim clinical teachers pressed their demands for registration, pointing out the inconsistancy of granting paid study leave and course fees for clinical teacher students but witholding recognition from them once they had qualified. (71,72)

Many assumed that statutary recognition would lead to a separate salary scale which would reflect the clinical teacher's experience and additional qualification, but even if it did not, registration was felt to be valuable. It was argued that the existence of trained clinical teachers improved the quality of ward teaching and enhanced the status of the nurse in training and so would help to

reduce wastage. In turn the recruitment of clinical teachers would be better if they were formally recognised because such recognition would enhance their status - an important consideration because there were some who felt that they had been demoted by becoming clinical teachers. (73-79)

The clinical teachers claimed that the Minister of Health's conditions for registration indicated a complete misunderstanding of clinical teaching. They insisted that the supervision and teaching of learners was already part of the work of the staff nurse and that the teaching which clinical teachers did implied much more than that.

> "She mediates between the ward sister and the nurse. She liaises between the ward sister, the administrative staff and the nurse teaching department. She not only acts as guide, counsellor and friend to all members of staff, but supports them, including the staff nurse, when necessary." (80, see also 81-86)

This could only be done by an experienced nurse and not by one who was herself still learning, as the newly qualified staff nurse must be.

Not only did they feel themselves to be misunderstood, clinical teachers also considered themselves to be disadvantaged financially. It was understandable that ward sisters who undertook a further period of training and were then employed by the school of nursing to work alongside tutors should seek a new salary scale which would reflect their new occupation. Registration, by conferring statutary recognition on clinical teachers, was expected to lead to such a new salary scale. Between 1962 and 1968 it was a cause of some bitterness for Scottish clinical teachers that in spite of their registration they were unable to negotiate a new salary until the General Nursing Council for England and Wales also offered registration. (87,88) In the event, no separate grading was provided for clinical teachers until 1974.

This was a source of considerable concern, particularly after the introduction of extra duty payments. These extra payments were made for evening and week-end work and were not normally available to teaching staff who were not expected to work at unsocial hours. The position of clinical teachers was variable. As teaching staff they were not expected to claim extra duty payments, yet many of them felt that they should be on duty at the same times as their learners. Most clinical teachers, even after the 1970 pay award, found that their take-home pay was considerably reduced and for many the fact that they might no longer be required to work in the evenings or at the week ends was small compensation. (89-91)

Both Councils had recommended that clinical teachers should be employed by the school of nursing, and in Scotland that pattern quickly became the norm. In England, perhaps because the Area Nurse Training Committees were less able to make monies available for the employment of clinical teachers, they might be attached to nursing service, and it was not unknown for hospitals to advertise for 'unqualified clinical instructors' to work from the nursing administration office and undertake administrative as well as teaching duties. Registration enabled the General Nursing Council to exert more control over the employment of clinical teachers because it clearly designated them as teaching staff, and this meant that the Council had to approve candidates for courses and release money for their employment after qualification.

The whole issue of registration and the creation of a separate salary scale for clinical teachers illustrates well the conflict between the two prescriptions for clinical teaching. The insistance that clinical teaching should be open to staff nurses, the assumption that they would

be paid as ward sisters and the suggestion of the committee on senior nursing staff structure that clinical teaching posts should be seen as training posts for prospective tutors, are all consistant with the first prescription. If the teaching which such a clinical teacher was able to do was fairly narrowly defined, this too was in keeping with that prescription. On the other hand, the Rcn and the clinical teachers themselves and, to some extent the General Nursing Councils, in their advocacy of ward sister experience and a wider teaching remit were following the second prescription. In Scotland the Council's insistence on ward sister experience meant that recruitment followed the second prescription while pay and conditions of service were compatible with the first, with the discrepancy between them creating dissatisfaction and resentment amongst the clinical teachers.

The English Council's acceptance of the Minister of Health's terms for registration might have been expected to tip the balance in favour of the more restricted clinical teaching role. Indeed one of the criticisms levelled at the Council at the time was that it had allowed "dictation from political groups as to what is required in the way of professional experience".(92,93) That this did not happen was partly due to the unwillingness of candidates to come forward, or of schools of nursing to support them, without ward sister experience. Since the colleges offering preparatory courses also continued to stress the advisability of having ward sister experience the same kind of conflict continued in England as in Scotland. When the committee on senior nursing staff structure published its report, many clinical teachers saw a solution to their financial and status problems in the nursing officer grade, and when that structure was introduced a high proportion of clinical teachers took up these new posts. (94-96)

In Scotland the introduction of new "Wider Basic Training" schemes in 1962 stimulated interest in clinical teaching and during the nineteen sixties a number of attempts were made to find out how clinical teachers were being used and to assess what was happening. (97-102) One of these, perhaps the most comprehensive of them all, was carried out in 1967 by six Kings Fund trained clinical teachers who kept diaries of their activities and carried out a survey of all of the past students of the Kings Fund course. (100) That study gives a fairly straight forward account of such things as the general pattern of the clinical teachers' day, their communication networks, the type of teaching being done, differences in hours worked, types and numbers of learners dealt with, and ward allocations, and its results are reflected in the other studies which drew on different populations, although in some cases there may have been some overlap.

The organisation and implementation of clinical teaching

It will be remembered that the two prescriptions identified above, differed quite markedly as to the kind of teaching which the clinical teacher was expected to do. Clinical teachers who adopted the second prescription insisted that the teaching that they were doing was a "very special form of teaching" (103), requiring "a new way of thought" (104), and that it was quite different from, although complementary to, the teaching done by the ward staff or the tutors. (105,106)

Not only was their teaching not confined to the demonstration and supervision of practical procedures, it was also concerned with explaining the treatment and care which individual patients were receiving, thereby integrating 'theory' with practice and giving the students the support and supervision which ward staff were unable

to give, both because of their other commitments and of their lesser knowledge of the students and their training programmes. To clinical teachers, the first prescription, with its emphasis on procedures, was quite inadequate as a description of what clinical teaching actually involved. However, the 1967 study mentioned above showed that

> "It is certainly true to say from the diaries that the clinical instructors spend a great proportion of their time at the bedside working with and supervising the student nurse in carrying out practical procedures and on more technical things such as lumbar puncture, ... Discussion is nearly always mentioned in connection with the procedure, usually informally while clearing away or in any room or corner available." (107)

Other descriptions by clinical teachers seemed to confirm that nursing procedures were used as the vehicle for a high proportion of the teaching, whether that teaching was confined to the procedure or was more wide ranging. (108-111) Where these descriptions do differ from the first prescription is in the emphasis which they put on working with learners for prolonged periods to carry out the work which had been allocated to them, rather than visiting the wards specifically to carry out particular procedures, as is implied by the material which gave rise to the first prescription.

In order to work with learners in this way, the clinical teachers maintained that they had to know the ward and its patients well and this meant having a limited number of wards to work in. In spite of this, the reality seems to have varied from three or four wards with 15-30 learners and 50-100 patients, (which allowed the clinical teacher to be conversant with ward staff and routines, learners and patients and to spend a fair amount of time with each learner, but, where clinical teachers were in short supply, left learners in other wards of the

hospital uncatered for) to all the wards of the hospital, either going with the members of a particular class or set as they moved through their programmes of clinical experience, or trying to see all the learners in all of the wards. The sheer numbers of staff, learners and patients involved in these last methods militated against the kind of teaching described above, as did the variety of knowledge required for the different specialties. Presumably, therefore, those whose work was organised in this way were unable to follow the second prescription and some of them complained about this.

Another factor which reduced the amount of time which could be spent with individual learners was the clinical teacher's commitment to the school of nursing. Just what form this commitment took is not clear, although from the fears expressed about the clinical teacher being used to assist the tutor, it must be assumed that some of it at least was classroom teaching rather than preparation, planning or record keeping for which time might also be made available within the working week. (112-114)

Hours of duty varied depending on whether the clinical teacher was responsible to the school of nursing, the matron's office or some other department, and many clinical teachers had flexible hours, working occasional evening, weekend and night duties, although others worked a 'college week'.

The clinical teacher and the nurse tutor

One aspect of the subject which has hardly been explored so far is the relationship between the clinical teacher and the nurse tutor. It has been noted in passing that some concern was felt by the General Nursing Council for Scotland when it was considering proposals for

a preparatory course that the employment of clinical teachers might mask the shortage of nurse tutors to the long term detriment of nurse training, (Page 165) and that there were fears that in some areas clinical teachers were being used as assistant tutors in the school of nursing rather than as clinical teachers in the wards.

Reference has also been made (Page 112) to the tutors' efforts to establish themselves as a distinct occupation within nursing and to their sensitivity about their status compared with both nurse administrators and teachers in other spheres. Irrespective of whether she was recruited as a staff nurse or as a ward sister, the clinical teacher was formally of lower 'rank' than the tutor, but she nevertheless seems to have posed a threat to the tutor's informal status.

Tutors had expressed the opinion that the clinical teacher should be employed as a member of the teaching staff, thus implying that clinical teaching was to be seen as a development of the school of nursing's remit rather than as an extension of the ward staff's teaching. Where they were employed as teaching staff, clinical teachers were responsible to the senior tutor and were controlled by her. Therefore, it might be thought, in view of the tutors' efforts to establish a professional identity for themselves, that the emergence of a subordinate group would be welcomed. That this was not always so, requires a closer examination of the expected role of the clinical teacher and its implications for the nurse tutor.

As has been shown the tutor made much of their claim to knowledge of educational methods and educational theory by virtue of a two year university based course, on the basis of which they were afforded statutory

recognition by the General Nursing Councils and given the right, denied to other nurses, to teach all subjects in the curriculum. Yet in the nineteen fifties a substantial proportion of nurses in teaching posts had not undertaken a tutor's course and were therefore graded as "unqualified tutors".(115) If to these were added more teachers who had either had no preparation for teaching, or, after 1958, had followed a six month non-university based course, there was a danger that the legitimacy of the tutor's claims would be undermined. Statutory recognition, because it implied that the qualified clinical instructor was a teacher in her own right, prepared for the specific task of teaching in the clinical area, and was not to be regarded merely as a substitute for the tutor, threw this problem into sharp focus.

Many tutors, therefore, were at pains to emphasise the clinical teacher's subordinate status and that she should have no responsibility for classroom teaching but should augment ward teaching. (116) However, this gave rise to another danger - that the tutor's already limited contact with the wards might be reduced still further - though this should not be seen as a separate issue. Rather they are both facets of the question of the tutor's credibility as a nurse and her claim to be a teacher of nursing rather than nurses. Reference has already been made (chapter 2) to the split which was perceived to have developed between nurse education and nursing service, which was exemplified in Dodd's findings that students tended to think of the school of nursing as 'the place where they learned to pass examinations' and the wards as 'the place where they learned to become nurses' (117), and that twenty years earlier Downer had warned that in time the learner might come to regard the clinical teacher rather than the tutor as her 'real' teacher.(118)

By virtue of the fact that she would occupy a position between the ward and the training school, the clinical teacher was likely to emphasise the separation between them. But it was more than that. The clinical teacher might be formally employed as part of the staff of the school of nursing under the control of the senior tutor (and that was by no means uniform practice in the early days of clinical teaching) but she was nevertheless employed to work in the wards and might even be claimed to be a part of the ward 'team' even though she was not a member of its staff. (119-121) She was thus able to maintain that involvement with patient care and contact with medical staff which the tutor had to some extent forfeited because she was now at one remove from the life of the ward. It is difficult to determine just how important a source of informal status and prestige these contacts were, but reading nursing literature and listening to contemporary nurses it is hard to escape the conclusion that they did then and do now provide a potent source of prestige and credibility for the clinical nurse which is not available to those who are no longer employed 'at the bedside'. However, just as it was assumed that the ward sister should be responsible for the ward teaching of the learner, so there was an implicit assumption that the tutor should and did teach in the wards no matter how little teaching she actually did do there. The danger was that the clinical teacher might by her very presence in the wards not only reduce the tutor's appearances in the ward but challenge their legitimacy and complete her 'imprisonment in the classroom.' (122-123)

To be sure, some tutors admitted that they were unable to provide the kind of support and tuition which the learners required in the wards and suggested that they should relinquish any attempt to do so (124-125), a

state of affairs acknowledged by the Rcn Tutor section in 1961 although they were adamant that "All tutors should undertake clinical instruction in the wards ..." and adapted a 'wait and see' attitude to clinical teachers, merely commenting that "in some cases there have been misunderstandings as to how their duties should be interpreted" (126) Perhaps it was these misunderstandings that prompted the Ward and Departmental Sisters' Sectional Committee to stress the need for a definite policy for clinical teaching and to urge that it is "essential that they (clinical teachers) should be considered part of the ward team and not second rate tutors" (127) The dilemma for the tutor, then, was that the clinical teacher would either pose a threat to her credibility as a nurse or to the legitimacy of her monopoly of nurse teaching.

As long as clinical teachers formed a small minority of teaching staff these problems could be contained, but as their numbers increased and they began to form a significant proportion of the staff in some schools of nursing, the relationships became increasingly uneasy. Matters were not improved by the shortage of nurse tutors. It was tempting for them to delegate some of their work to clinical teachers, but the more blurred the distinction became between the functions of the two kinds of teacher, the more dissatisfied the clinical teachers became, pointing out that they were neither qualified, nor paid, to undertake this kind of work and that the more time they spent in the school the less they were able to do 'real' clinical teaching.

In clinical teaching, then, a similar kind of situation was developing to that which has already been identified in nursing education as a whole and in nursing generally, in that while a number of specific problems

were discussed there seems to have been little attempt to deal with the underlying problem of defining the proper function of the clinical teacher and her relationship to the nurse tutor. Just as the 'superficial repair' approach which was adopted in attempting to deal with the problems of nursing generally can be seen reflected in the ways in which the problems of nursing education were discussed so it can also be seen in the discussions of the problems of ward teaching and of possible ways of solving these more specific problems. This is illustrated in figure 9.

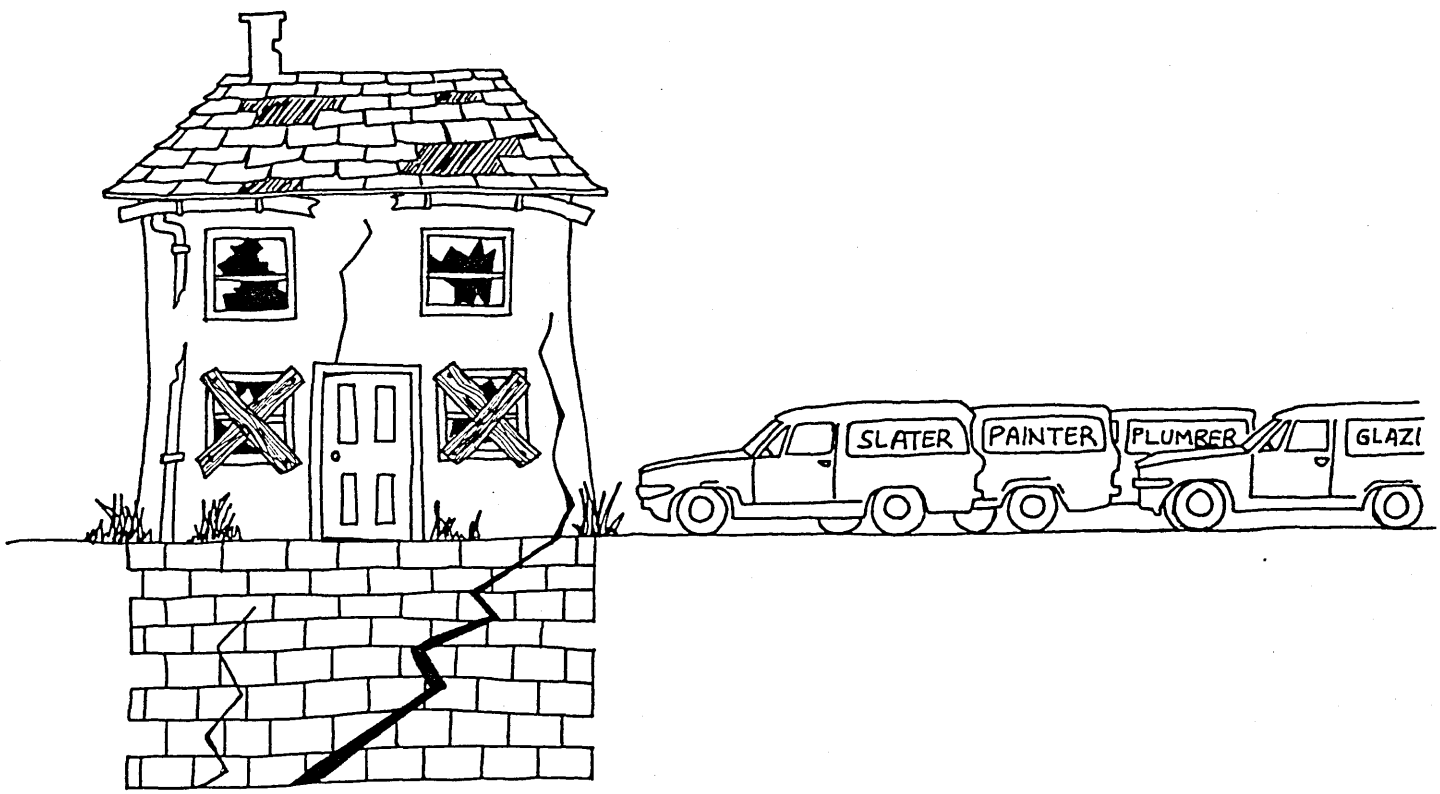


Figure 9 The 'superficial repair' approach reflected in nursing education and in nursing.

Figure 5, which first appeared at the end of chapter two (Page 50), illustrates the way in which a preliminary exploration of the problems of clinical teaching led to both an historical and an observational study.

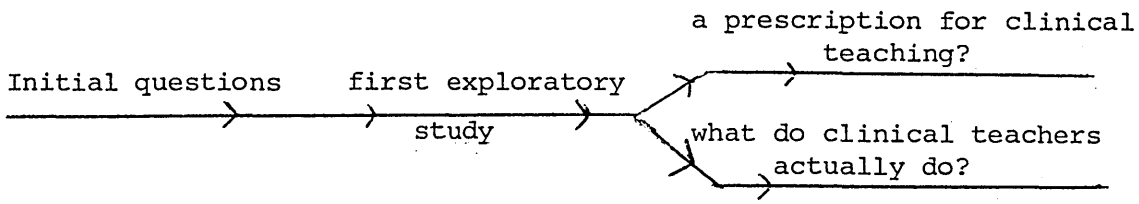


Figure 5 The sequence of the enquiry leading to the historical and observational studies.

The historical study was designed to answer the question

> is there any generally agreed prescription of what constitutes the work of the clinical teacher?
> i.e. of the boundaries between 'tutoring' and clinical teaching, and of the clinical part of the work?

It has shown that, rather than there being one historically derived ideal role or model, there were from the beginning considerable differences in the ways in which clinical teaching was perceived. Although the whole subject is somewhat confused and ambiguous, it has been possible to identify two models which are not clearly defined but which do differ in important ways. It has also been shown that from the beginning the boundaries between 'tutoring' and clinical teaching were poorly defined.

Neither model appears to have been followed consistently, but since each has implications for the ways in which clinical teaching is organised, the resulting compromise

acted as a potent cause of dissatisfaction for clinical teachers because their attempts to follow their own prescription were constrained by an organisational structure patterned on the more circumscribed model.

The problems which have been identified from the historical data bear a similarity to the problems discussed in chapter two and they have been tabulated on page 171 using the categories developed in that chapter. However, the nursing service as a whole, and nursing education as a part of it, are very different today from what they were in the periods so far considered.

The number of clinical teachers in post has grown markedly, particularly in Scotland where there are now four preparatory courses and where some colleges of nursing employ more clinical teachers than they do tutors.

Many tutors also hold clinical teaching qualifications, and it is increasingly being stressed that tutors need to establish firm contacts with the wards.

Since 1974 the statutory body in Scotland* has tended to see nurse teacher certification as a serial qualification with the majority of candidates practising as clinical teachers for a year or two before going on to undertake a nurse tutors' course - a policy which is reminiscent of the suggestion of the committee on senior nursing staff structure that clinical teaching should be seen as a training grade. The General Nursing Council for England and Wales declared its intention to phase out the two separate grades of teacher in favour of a generic teacher who would operate in both spheres, although this intention has not so far been acted on. The establishment of the UKCC and National Boards has generated considerable concern amongst clinical teachers in the light of the different

*The General Nursing Council until 1983. The National Board for Nursing, Midwifery and Health Visiting since then.

stances of the former General Nursing Councils.

Basic training programmes have changed substantially since 1962 and have grown in both width and depth.

Nursing practice is changing in response to advances in medical science and technology, demographic trends and the changes in cultural patterns and the expectations of society.

Perhaps the most significant change of all is in the ways in which nurses are conceptualising and therefore organising and teaching nursing. No longer do they automatically think in terms of a hierarchy of tasks based on a medical model of care. The introduction of the nursing process, as a concept, if not always as a method of providing care, has accelerated the move towards patient allocation and the development of nursing models of care. Although the length of training remains the same, the increasing busyness of wards, the shorter working week and longer annual leave allowance has effectively reduced the time in which a learner can interact with any member of the trained staff.

In the light of these changes it cannot be assumed that, because the ways in which current problems are expressed and described are similar to the ways in which the problems foreseen in the nineteen forties and fifties and experienced in the nineteen fifties and sixties were expressed and described, theproblems themselves are the same. The extent to which the present problems and dissatisfactions of clinical teachers are a continuation of the ambiguities and unresolved conflicts of the past, or the result of new factors, is a matter for investigation. The observational study which is now to be considered, does, however, suggest that some of the problems spring from the same source.

References for chapter six

1. Weddel D. (1954) Letter - Future Schools of Nursing Nursing Times 50 (18th Sept) p 1024

2. West E. (1954) Letter - The Ward Sister as Teacher Nursing Times 50 (30th Jan) p 132

3. Skellern E. (1953) Report of an Investigation carried out "to study, report and make recommendations on the practical application to ward administration of modern methods in the instruction and handling of staff and student nurses" Rcn London

4. McNaughton M. (1949) Experiments in Nurse Training 1 Nursing Mirror 89 (13th Aug) p 308-310

5. Nursing Times (1953) Report of Rcn Conference on the Job Analysis Report Nursing Times 49 (5th Dec) pp 1238-1240

6. Nursing Mirror (1955) Report of the Association of Scottish Hospital Matrons Discussion: Clinical Teaching of Student Nurses Nursing Mirror 100 (20th May) p 421

7. Nursing Times (1953) Change of Direction - Editorial Nursing Times 49 (14th March) p 253

8. Letter (1953) Ward Sister's Difficulties Nursing Times 49 (15th Aug) p 830

9. Nursing Times (1947) Clinical Instructors - Editorial Nursing Times 43 (20th Sept) pp 647-648

10. Yates P. (1948) Suggested Improvements in the Methods of Training Nurses Nursing Mirror 87 (21st Aug) pp 327-328

11. Woolcoombe E. (1947) Letter - Unnecessary Duties Nursing Times 43 (1st Nov) p 771

12. College Member (1948) Letter - Wastage of Nurses in Training Nursing Times 44 (10th Jan) p 33

13. Armstrong R.F. (1948) Letter - Student Tutor Nursing Times 44 (24th Jan) p 66

14. Bell L.M. (1949) Some Impressions of the Use of Clinical Instructors Nursing Times 45 (16th July) pp 581-582

15. Bourne J.H. (1950) Clinical Instruction Nursing Times 46 (22 July) pp 750-752, 762

16. Downer A. (1949) Dangers of Clinical Ward Instructor and some Practical Alternatives Nursing Mirror 88 (30th Dec) pp 283-284, 289

17. Scales M. (1949) Letter - A Ward Sister's View Nursing Times 45 (30th Oct) p 804

18. Dodd A.P. (1973) Towards an Understanding of Nursing Ph.D. Thesis University of London

19. Davies C. (1977) Continuities in the Development of Hospital Nursing in Britain Journal of Advanced Nursing 2:5 (Sept) pp 479-493

20. Beck J. (1960) Letter - Clinical Instructors Nursing Times 56 (10th June) p 728

21. Lancet (1955) Training the Nurse - Comment on the report of the Scottish Standing Nursing and Midwifery Committee Lancet 55 (16th April) p 804

22. R.N.T. (1962) Letter - Back to Bedside Teaching Nursing Times 58 (2nd Feb) p 147

23. Capener R.C. (1962) Letter - Clinical Instructors Nursing Times 58 (8th June) p 746

24. McOnegal K.M. (1949) The Role of the Practical and Clinical Instructor in a British Hospital Nursing Times 45 (16th July) 571

25. Ashbee M.P. (1948) Letter - Practical Teaching Experiment Nursing Times 44 (7th Feb) p 105

26. Biddlecoombe V.M. (1949) Experiment in Nurse Training - 4 Practical Instructor in the Wards Nursing Mirror 89 (15th Oct) pp 43-44

27. Nursing Mirror (1950) News Item Nursing Mirror 91 (28th April) p 70

28. Nursing Times (1951) Report of Rcn Tutor Section Winter Conference Nursing Times 47 (2nd March) p 221

29. "P.D.N." (1959) The Leicester Experiment Nursing Times 55 (23rd Oct) pp 1034-1036

30. General Nursing Council (1959) Report on Nurse Training Nursing Times 55 (27th Nov) pp 1180-1181

31. Department of Health for Scotland: Scottish Health Services Council (1955) The Work of Nurses in Hospital Wards H.M.S.O. Edinburgh pp 8,9

32. Scottish Home and Health Department (1963) Experimental Nurse Training at Glasgow Royal Infirmary H.M.S.O. Edinburgh

33. Nursing Times (1961) Bedside Teaching - Editorial Nursing Times 57 (3rd Feb) p 133

34. Brook E.E. (1977) Hospital Teaching Practice Unpublished paper prepared for a middle management course.

35. Timmins G. (1960) Letter - Teaching at the Bedside Nursing Times 56 (14th Oct) p 1285

36. Needham R.C. (1962) The Staff Nurse as Clinical Instructor Nursing Mirror 115 (14th Dec) pp 231-232

37. Bennett B.A. (1961) Teaching and Teaching of Nurses 1. the education of the nurse Nursing Mirror 111 (6th Jan) pp ii, iii, and 1254

38. Bennett B.A. (1962) Who Should Give the Clinical Instruction? Nursing Mirror 114 (14th Sept) pp 463 and 470

39. Geddes J.D.C. (1960) Letter - Teaching at the Bedside Nursing Times 56 (28th Oct) p 1348

40. Dunlop A.J. (1962) Letter - Giving Clinical Instruction Nursing Mirror 115 (5th Oct) p 14

41. Geddes J.D.C. (1963) Letter - Staff nurse as Clinical Instructor Nursing Mirror 115 (11th Jan) p 329

42. Crossland G.A. (1966) Letter - Nursing Times 62 (19th Aug) p 934

43. Kirk G. (1962) Letter - Bedside Teaching Nursing Times 58 (13th July) p 906

44. Machin D. (1966) Letter - Clinical Instructors and Salmon Nursing Times 62 (1st July) p 720

45. Nursing Times (1956) The Clinical Sister Tutor and her Place in the Ward Team - Report of Rcn Tutors' Conference Nursing Times 52 (3rd Aug) pp 732-734

46. Morgan W.F. (1958) Experimental Training Scheme at Glasgow Royal Infirmary Nursing Times 54 (12th Sept) pp 1056-1057

47. McOnegal K. (1949) *op.cit.*

48. Young U.J. (1948) Letter Nursing Times 44 (4th Dec) p 896

49. Department of Health for Scotland (1955) *op cit*

50. Nursing Mirror (1961) Nursing in the service of the Patient: Report of the third Nursing Mirror Lecture Nursing Mirror 112 (2nd June) pp 829-830

51. Nurses and Midwives Whitley Council (1965) Circular 124. Salary Scales and Conditions of Service for Clinical Instructors Whitley Councils for the Health Service London

52. National Board for Prices and Incomes (1968) Pay of Nurses and Midwives in the N.H.S. Report No.60 H.M.S.O. London

53. Committee on Senior Nursing Staff Structure (1966) Report H.M.S.O. London

54. Student Nurse (1959) Letter - Ward Teaching Nursing Times 55 (12th Sept) p 901

55. McPherson E. and Brooks J. (1959) Letter - Ward Teaching Nursing Times 55 (16th Oct) p 1011

56. Martinson E. (1963) Letter - Clinical Instructors in Mental Hospitals Nursing Times 59 (2nd Aug) p 892

57. Nursing Times (1965) Students Want Clinical Instructors - Report of the Student Nurses' Association Central Representative Council Meeting Nursing Times 61 (2nd April) p 288

58. General Nursing Council for England and Wales (1963) Annual Report April 1962 - March 1963 G.N.C. London

59. Nursing Reconstruction Committee (1943) Report Rcn London

60. Weddell D. (1954) *op.cit.*

61. McMillan A. (1965) Views on Current Talking Points - Why Registration? Nursing Times 61 (2nd April) p 292

62. Emmens A. (1967) The Clinical Instructor in a Psychiatric Hospital Nursing Times 63 (28th April) p 356

63. Department of Health for Scotland (1955) *op.cit.* p 9

64. Rcn Scottish Board (1959) Unpublished Report on the first course for clinical instructors Rcn Edinburgh

65. Geddes J. (1960) The Potential Clinical Instructor Nursing Times 56 (24th June) p 981-782 and 786

66. News of the Week (1965) Nursing Times 61 (12th Feb) p 196

67. 43 Clinical Instructor Students, Edinburgh (1965) Letter Nursing Times 61 (19th Feb)

68. Nurses and Midwives Whitley Council (1965) *op.cit.*

69. Committee on Senior Nursing Staff Structure (1966) *op.cit.*

70. News Item (1968) Bargaining with Clinical Instructor Registration Nursing Times 64 (24th May) p 688

71. League of Edinburgh Trained Clinical Instructors (1965) Letter - Grinding to a Halt Nursing Times 61 (1st Jan) p 29

72. Hector W. (1965) Letter - Grinding to a Halt Nursing Times 61 (1st Jan) p 29

73. Nursing Times (1964) Grinding to a Halt - Editorial Nursing Times 60 (4th Dec) p 1589

74. Darwin J., Green M., Chatfield K. (1964) Letter - Grinding to a Halt Nursing Times 60 (11th Dec) p 1641

75. Cowie J. (1965) Letter Nursing Times 61 (16th April) p 521

76. Wilson J., Reid J., Connechan M. (1968) Letter Nursing Times 64 (1st Nov) p 1489

77. Nursing Times (1965) The Clinical Instructor Grade - Editorial Nursing Times 61 (10th Sept) p 1225

78. McMillan P. (1965) Letter Nursing Times 61 (24th Sept) p 1317-8

79. Brodie M.E. (1965) Letter Nursing Times 61 (16th April) p 521

80. Dutton N.P. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 773

81. Treadway G. (1965) Letter Nursing Times 61 (31st May) p 739

82. Backhouse N. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 773

83. Dodds J. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 773

84. Singleton B. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 773

85. Horner H.S. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 773-4

86. Cobden P. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 774

87. Geddes J. (1965) Letter - Grinding to a Halt Nursing Times 61 (1st Jan) p 29

88. League of Edinburgh Trained Clinical Instructors (1965) *op.cit.*

89. Osborne J., and O'Neill R.B. (1968) Letter - Clinical Instructors Nursing Times 64 (9th Aug) p 1083

90. Copeman J.H., Tucker M.M., Sumner P., Jenkins J., Barlow E. (1970) Letter - Clinical Teachers' Salary Award (NMC152) Nursing Times 66 (9th July) p 887

91. Treadway G. (1970) Letter - Clinical Teachers Nursing Times 66 (6th Aug) p 1015

92. Holder S.J. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 774

93. Allen M. (1968) Letter - Registration of Clinical Instructors Nursing Times 64 (7th June) p 774

94. Robertson H.E. (1966) Letter - Clinical Instructors and Salmon Nursing Times 62 (8th July) p 918

95. McLeod K. (1968) Letter Nursing Times 64 (6th Sept.) p 1210

96. Tucker H.M. (1971) Letter - Clinical Teacher to Nursing Officer Nursing Times 67 (4th March) p 273

97. Rcn Tutor Section (1963) Questionnaire on the Clinical Instructor Nursing Times 59 (13th Dec) p 1563

98. King's Fund Staff College (1966) Clinical Instructor's Progress Nursing Times 62 (1st April) p 453

99. League of Edinburgh Trained Clinical Instructors (1968) Unpublished Survey

100. Treadway G.E. (1967) We Looked at Ourselves Nursing Times 63 (7th April) p 448

101. Barnes M. (1965) Some Thoughts and Experiences of Clinical Teaching Nursing Mirror 121 (31st Dec) p 415

102. Nursing Times (1965) Scottish Success Story - Editorial Nursing Times 61 (12 Nov) p 1532

103. McMillan P. (1965) Letter - Clinical Instructors' Evaluation Nursing Times 61 (24th Sept) p 1317

104. Anon (1960) Letter - Clinical Instructors Nursing Times 56 (12th Feb) p 104

105. Hunter M.H.S. (1960) Letter - Clinical Instructors Nursing Times 56 (8th July) p 843

106. Assistant Tutor, Glasgow (1961) Letter - The Clinical Instructor Nursing Times 59 (24th Feb) p 252

107. Treadway G.E. (1967) *op.cit.*

108. Charleton J. (1960) Letter - Clinical Instructors Nursing Times 56 (24th June) p 786

109. Clinical Instructor, Edinburgh (1960) Letter - Clinical Instructors Nursing Times 56 (1st July) p 822

110. Therese, Sister M. (1963) Teaching in the Ward Nursing Times 59 (22nd Feb) p 225

111. Strong P.G. (1970) The Clinical Tutor in a Psychiatric Hospital Nursing Times 66 (22nd Jan) Occasional Paper p 13-16

112. Hastings B. (1963) Clinical Instruction in the Mental Hospital Nursing Times 59 (2nd Aug) p 1988

113. Nursing Times (1960) Report of Rcn Ward and Departmental Sisters Central Sectional Committee meeting Nursing Times 56 (9th Dec) p 1548

114. Thomson M.W. (1962) Letter - The Ward Sister and Clinical Instructors Nursing Times 58 (29th June) p 844

115. Royal College of Nursing (1959) Clinical Instructors' Course. Unpublished report of the first course.

116. Collins S. (1963) Learning to Nurse - 2. The London Hospital Nursing Times 59 (22nd March) p 363-6

117. Dodd A.P. (1973) *op.cit.*

118. Downer A. (1949) *op.cit.*

119. Nursing Times (1960) *op.cit.*

120. Bryant J.G. (1962) Letter - Back to Bedside Teaching Nursing Times 58 (23rd Feb) p 246-7

121. Hunter M.H.S. (1962) Letter - Bedside Teaching Nursing Times 58 (20th July) p 938

122. Nursing Times (1964) *op.cit.*

123. Nursing Times (1960) Teaching at the Bedside - Report of a special meeting of the Rcn Tutor Section Central Sectional Committee Nursing Times 56 (30th Sept) p 1201

124. Assistant Tutor, Glasgow (1961) *op.cit.*

125. McAuley K. (1963) Letter - Clinical Instructors Nursing Times 59 (28th June) p 815

126. Rcn Tutor Section (1961) The Nurse Tutor - a new assessment Rcn London

127. Nursing Times (1960) Teaching at the Bedside *op.cit.*

PART THREE

THE PRACTICE OF CLINICAL TEACHING

CHAPTER SEVEN

CLINICAL TEACHING OBSERVED

At the same time as the historical study was being undertaken an observational study was designed to answer the second question posed on page 49, namely,

"what do clinical teachers actually do in the wards?" This question arose from the exploratory study reported in chapter two which showed that there are a number of differences in the expectations which different groups of people have of clinical teachers and in the ways in which clinical teachers actually work, or are said to work. Before these differences and conflicts in expectations could be explored more information was needed about the clinical teacher's work and in particular about that part of her work which is carried out in the wards. Hence this phase of the study developed from and was grounded in the phase which preceded it, but, because they were carried out concurrently, it was also influenced by the historical study. This is particularly true of the way in which the categories were identified and amplified. As particular aspects of clinical teaching were identified in the historical data so they were sought for in the fieldnotes and similarly as particular events were observed reference to similar events was looked for in the historical data. In this way the two phases of the study each contributed to the other. This being so, there was the danger that thinking would be channelled to such an extent that only those things which were expected would be recognised. Lest this charge be made it is necessary to discuss the method of observation and recording in some detail.

In addition to countering a possible charge of a preconceived bias, discussion of the use of participant observation is required because of the confusion which exists between the perspective which considers the source of nursing to be in some 'real world' of nursing practice 'out there' and that which considers it to be in a mental construct of 'an ideal world' of nursing practice as it would be if it was done correctly (page 10)

This confusion has already been identified in relation to the exploratory study referred to above (see page 45), for it was not always possible to know whether those who completed the open questions were describing clinical teaching as they would have liked it to be or as they actually experienced it. The possibility of this kind of confusion is much greater when clinical teaching is being described and discussed than when it is being observed although the use of observation does not necessarily solve the problem altogether.

Within the general category of 'observation' a number of methods were available. On the one hand, for example, a quantitative analysis, using activity sampling, might have been possible, but this method provides little or no information about the content or context of the activity being observed and it is, therefore, more appropriate when the work to be observed is repetitive. It would, for example, identify the occasions on which a clinical teacher spent time speaking to trained staff, but the content and nature of those conversations would not be discovered.

On the other hand Goddard suggests that

> "where activities are numerous or constantly changing, as in nursing, continuous observation is necessary."(1)

Since it was likely that the clinical teachers to be observed would be taking part in numerous activities in a ward and that they would also be working in several wards in the course of a week, or even a day, thus providing numerous brief contacts with many people in a comparatively short space of time, it was this latter approach which was adopted. This approach also seemed to be appropriate in view of the time constraints which allowed only limited periods for observation over several months.

Continuous observation to the extent of 'shadowing' the subject, appears to offer the choice of two observer roles, namely 'participant-as-observer' and 'observer-as-participant'.

Becker describes the 'participant-as-observer' in the following terms -

> "The participant observer gathers data by participating in the daily life of the group or organisation he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events he has observed." (2).

This usually means joining the group to be studied and living their life, or at least some part of their life, with them; going to lectures with them, visiting patients with them, joining them for coffee and meals and taking part in their extra-curricular activities.

Although a great deal of information can be obtained from many sources by this method, it takes a considerable amount of time and energy. In addition, the observer is always in danger of becoming so integrated into the group that he overlooks significant items and has difficulty maintaining his objectivity. This is a problem which can be reduced by adopting an 'observer-as-

participant' stance in which there is less participation and the observer is able to withdraw at frequent intervals. This stance is also more suitable when it is necessary to engage in numerous brief contacts with many people, although it offers more limited opportunities for obtaining knowledge of the total situation. In practice the distinction between these two stances is not clearcut. Both Pearsall (3) and Byerly (4) for example, have commented on the tendency of the observer to vacillate between them, at times being less participant and more observer, and at times less observer and more participant.

Many writers have drawn attention to the problems associated with participant observation and there has been much debate as to the extent to which these can be resolved. A discussion of some of these problems as they were identified in the literature and encountered in this study was published in the Journal of Advanced Nursing (5) and is included as appendix 4. They will not, therefore, be discussed at any length here, although one or two comments are appropriate to illustrate the way in which this part of the study was conducted.

Although I had used observation in connection with the supervision and assessment of various kinds of learners, it had not been used as a research tool. It was therefore decided to arrange a 'trial run' in order to identify the likely problems and to determine which method of recording the observations would be suitable for this study. This observational study therefore, consists of two phases, the trial and the main phase, and these are reported separately. The table overleaf sets out the various components of the two phases and indicates the period during which they were accomplished.

	Trial Phase	Main Phase
No. of colleges	1	3
No. of clinical teachers	3	3
Total observation time	2 days for each subject	5 days for each subject
No. of questionnaires completed	7 tutors	3 clinical teachers 17 learners 34 trained staff
No. of interviews conducted	3 clinical teachers 1 DNE 1 senior nurse tutor	3 clinical teachers 2 DNEs 2 senior nurse tutors
Time Scale	March 1981	June 1981 December 1981

Table 2 Components and time scale of the observational study

In order to maintain anonymity, pseudonyms are used for all of the clinical teachers referred to in this chapter and the next, and for simplicity of reading, they will all be referred to as women although a few of them were men.

Each of the clinical teachers was used to having clinical teacher students with her as observers. They therefore, tended to explain and discuss what they were doing much as they would with a student. While this was useful in some ways, it meant that the pattern of the clinical teacher's activity was inclined to be distorted because much of this explanation and discussion took place during coffee and meal breaks or while going from one ward to another and these activities consequently took rather longer than would usually be the case.

As the observer was an experienced general nurse, explanations of ward activities, particularly in the general wards, could be kept to a minimum. There was,

however, a tendency to make assumptions and judgements about what was being done, based on experience, rather than simply to record what was happening. At first it was quite difficult at times not to participate in the activity and on occasion the clinical teachers too, tended to try to include the observer in the activity by asking for an opinion about what was happening or to seek the observer's views on clinical teaching. As time went on, it was possible to reduce these tendencies, and in most cases the clinical teachers seemed to get used to the observer's presence very quickly, even sometimes forgetting that she was there, particularly when they were carrying out nursing care with learners.

The Trial Phase

A small college of nursing was chosen and the requirements of the study were discussed with the director of nurse education and her clinical teachers. It was arranged that the clinical teachers would be observed for one full day and two half days when they had no meetings or classroom commitments. It was stressed that they should ignore the observer as far as possible and do what they would 'normally' do.

Three clinical teachers were observed.

Anne was a member of the teaching team which was designated as dealing with 'mental and the elderly'. Her allocation was to two long stay geriatric hospitals and the four geriatric assessment wards which were situated in a third hospital. These hospitals were several miles distant from each other and from the college of nursing. At any given time there may have

been two or three pupils allocated to the long stay units but the majority of the pupils and all of the students worked in the main hospital in which *Anne* had an office and in which she spent the greater part of her time.

Anne had worked in this hospital for many years, most of them as an assistant matron or nursing officer. She first considered clinical teaching in the late 1950s but was unable to pursue it at that time. She had been a clinical teacher for five years. When changes in the designation of the main hospital also necessitated changes in the organisation of the clinical teaching there, it was mutually agreed that she would change from acute medical to geriatric wards.

She worked with fairly small numbers of learners at a time, eight or nine being the average number allocated to the wards in which she taught. This meant that there may only have been one or two on duty in a ward or hospital on some occasions. *Anne* went to each of the hospitals on set days, and, in the case of the smaller hospitals, she normally spent the whole day there. At one time an arrangement had been made with the ward sisters that all the learners would be on duty at some time during that day, but at the time of the observations this arrangement was beginning to break down and *Anne* had not as yet tried to find out why.

Joan was also a member of the teaching team which dealt with 'mental and the elderly'. She was allocated to half of a large psychiatric hospital in town and to the whole of a smaller rural one about half an hour's drive away from the college. The large hospital, in which *Joan* had an office, was at the other end of town from the college and was fairly spread out, the most distant wards being about twenty minutes' brisk walk from

each other. *Joan* had been a clinical teacher for four years and before that was a sister in the smaller of the two psychiatric hospitals. There were usually about six learners working in the smaller hospital at any one time and *Joan* had an arrangement that they would all be on duty on the one day a week that she spent there. In the main hospital there were usually twenty to thirty learners in her wards at a time. She concentrated on these learners who were about to sit intermediate or final examinations and tried to see as many of them as possible in a week.

Karen was a member of the 'general' teaching team and was responsible for one medical and two surgical wards. She did not "actually do any teaching in the accident and emergency department or theatres" although it was also part of her allocation, but she went there once a week just to visit the learners and the trained staff. Her wards were all housed in one building in which she also had an office which she shared with the other clinical teacher in the 'general' team. *Karen* had been a clinical teacher for two years and prior to that was a nursing officer in the hospital for six years, mostly on night duty. The numbers of learners in the three wards varied considerably from about eighteen to about thirty at the time of the observations.

Whichever method of observation is chosen it is unlikely that the observer will be able to make sufficiently full fieldnotes during the observation period, if only because in doing so she may miss much that should be observed. All authorities therefore recommend the making of as full and detailed an account as soon as possible immediately after the observation period.

Since I was uncertain about how much detail would be required and about my ability to recall all but a fraction

of what had happened during any observation period, I decided to take notes freely during the observations and use these as the basis for a fuller account written immediately after each observation period. At first I attempted to note what the clinical teacher was doing at intervals of about a minute, but this system proved to be unmanageable and too rigid and was replaced by a note of each change of activity. As far as possible these notes included reference to the time, the activity, the other people involved, the circumstances and what was said by whom, and the observer's comments and reactions. The amount of detail that was possible varied greatly but as these notes were intended only as an aide memoire often single words were sufficient, provided an indication of the time was also given.

Immediately following the observation period as full an account as possible was made of the activities, speech, surroundings and people. This account was made in duplicate and the copy was later cut up into coherent sections which were then stuck onto cards which allow for indexing under as many headings as seemed appropriate. Initially, the categories developed from the first exploratory study were used but as each account of an observation period was read over new or more detailed categories suggested themselves and were incorporated into the indexing system.

The total observation time during the trial phase was quite short and it was not until the last few periods of observation that this system was worked out adequately.

The length of the observation periods was also a matter for concern. The longer the period is the more detailed are the rough notes which are required for accurate recall, the shorter it is the fewer notes will be needed on which to base the detailed records. Equally,

the shorter the observation period the less tiring it is but the longer the period the more complete is the picture that can be obtained. Even with participation reduced to a minimum the need to concentrate on all aspects of what was being observed and the amount of standing was found to be very tiring. It was this, coupled with the amount of time which was required immediately after the observation period to write up as full a record as possible, that became the deciding factor in planning for future observation periods of about three hours at a time. However, because it was felt that this did not give the flavour of the clinical teacher's whole day it was decided that for the main phase at least one whole day would be spent in observation even though that day might be less fully recorded than the shorter periods.

This was intended primarily as an observational study but during the trial phase there were many occasions when a ward sister or staff nurse asked questions about the study. At these times the questioner often volunteered her opinion of clinical teaching and it would have been possible to discuss this with her and to invite her to complete a questionnaire. For the trial phase questionnaires were only used for tutors but in the light of this experience it was decided to use them for trained staff and learners in the main phase. In order to obtain information about the formal policy or structure within which the clinical teachers worked the director of nurse education and one of the senior tutors were interviewed.

The trial period was very brief, but it did serve its purpose in allowing the observer to make certain decisions about the general pattern of the observations e.g. the length of time that it took to write up an observation period, which in turn had implications for

the length of observation period that could be completed in the time available; the way in which the observer would introduce herself to the clinical teacher and to the other staff who would be encountered; and the type of record to be made. It also yielded valuable information about the pattern of the clinical teacher's day and provided a framework within which to plan the main phase of the observations.

Finally, the trial phase clarified the way in which the data should be analysed.

The Findings of the Trial Phase

The aim of the observational study was to find out "what clinical teachers actually do in the wards". The first level of analysis therefore, was to identify the components of the clinical teachers' day and the ways in which their time was divided.

The pattern of the clinical teacher's day

Although the clinical teachers worked in different hospitals and different fields of nursing, the broad pattern of their day was similar. All of them worked college hours; "officially 8.30 a.m. to 4.30 p.m. with approximately three quarters of an hour for lunch." However, not all of this working time was spent in the wards on the observation days. None of them went to the wards before 9 a.m. and one waited until 9.30 a.m. because

> "the learners go for coffee and the team cleaners are in the wards so it is not convenient to arrive before half past nine."

She had her own coffee before going to the wards while the others had a break later in the morning. All of them

left the wards between 12 and 12.30 p.m. one of them usually going home for lunch while the others brought in a packed lunch which they ate in their offices. None of them returned to the wards until 1.30 to 2 p.m. because "it's not convenient for them". The time between having lunch and returning to the wards was variously used to write up records read minutes of meetings, circulars, journals or text books, correct learners' written work, talk to other clinical teachers, contact wards about the afternoon's activities, or contact other members of staff. The afternoon work was arranged to fit in with the learners' tea break between 3 and 3.30 p.m. and all of the clinical teachers returned to their offices by 4 p.m. at the latest when the ward staff on the early shift went off duty. Records were again written up at this time.

Before going to the wards in the morning and again at lunch time, the clinical teachers consulted their copies of the ward duty rotas to see which learners were on duty, and decided which wards to visit, and which learners to see. One of them sometimes arranged this with the ward staff the day before but still consulted her duty rotas in the morning. Another contacted the wards before setting out, to confirm that the learner had come on duty and that it would be convenient to see her. On arrival in the ward all of the clinical teachers sought out the nurse in charge and spoke to her. At this time they sometimes also consulted the patients' kardex and/or case notes. They also sought out trained staff before leaving the ward.

In addition to the periods at the beginning, middle and end of the day, which might be termed 'slack' time, there was a variable amount of time in the wards during which the clinical teacher was waiting for the learner to become available, or waiting to speak to a member of

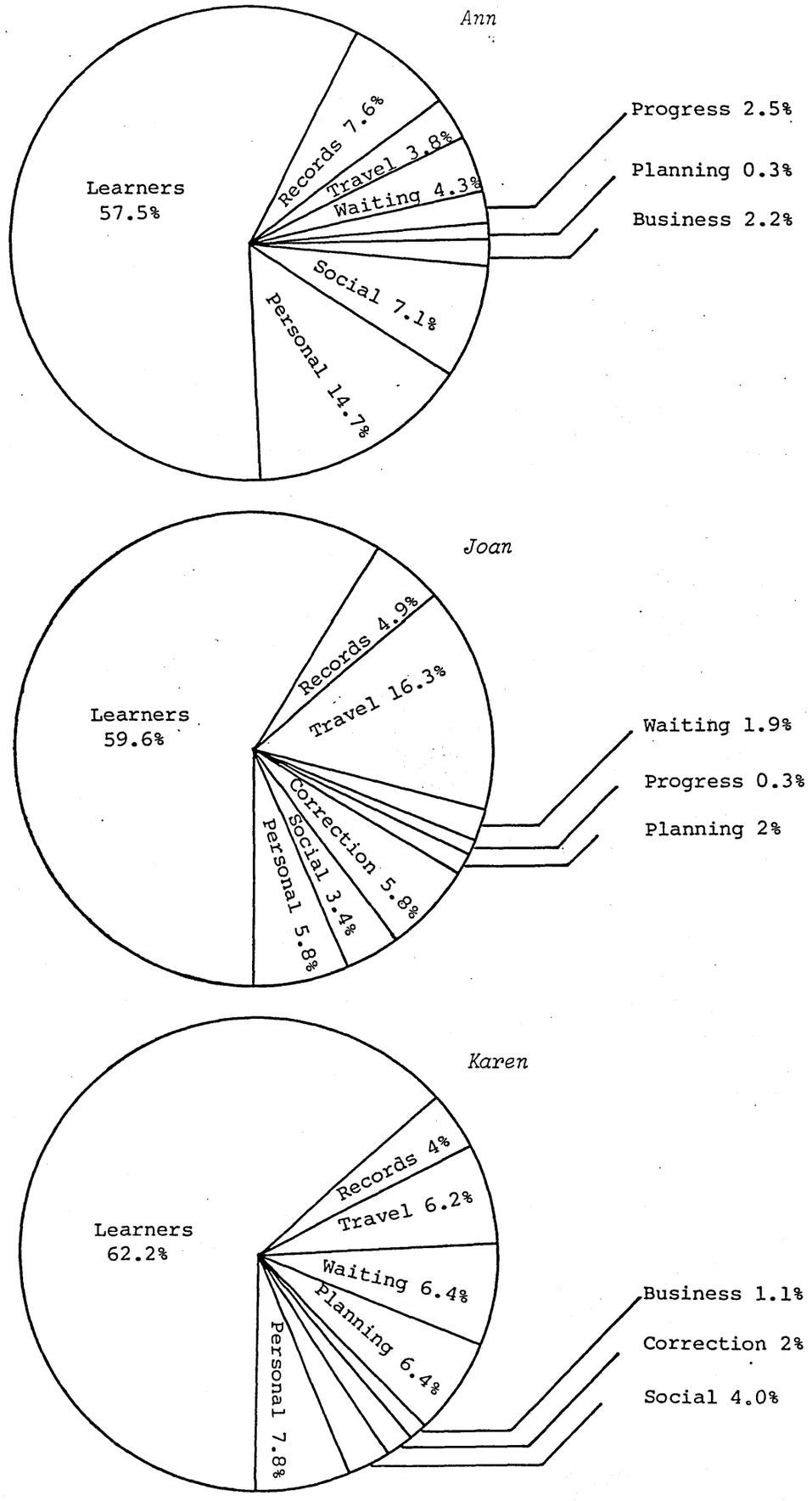
staff, or for some other reason appeared to be filling in time before, after, or occasionally during, a 'session' with a learner. During this time the clinical teacher might look at the ward off duty rota or notice board or 'chat' to patients or to other people in the ward.

The components of each clinical teacher's day, then, were the same, but the amount of time given to each varied considerably. The pie charts in figure 10 illustrate the ways in which each clinical teacher's time was divided during the observation periods.

Within this broad framework there was scope for considerable variation. For example, contact with the trained staff in the ward might vary from a brief exchange on the lines of 'Good morning, I've come to work with nurse so-and-so' to a half hour conversation embracing the weather, the busyness of the ward, the condition of some of the patients and the progress of the learners. Similarly the nature and length of the contacts with learners varied considerably. The pie charts (figure 10) give no indication of these variations, far less the reasons for them, or of the extent to which any one episode might have been more or less effective than any other, or of the relationship between any of the component activities.

The way in which the job is conceived and/or defined.

In this college the clinical teachers did very little classroom teaching. The psychiatric clinical teacher had the largest commitment averaging perhaps a day and a half a month, since she gave each group of 'seconded' pupils in each of her two hospitals an introduction to psychiatric nursing and to the hospital. The other two said that they did not do more than half a day in each introductory block (i.e. three times a year). These



Learner	All time spent with learners whether overt teaching was taking place or not. (However, this excludes casual social meetings with learners which would appear under the heading "social" time.)
Records	Three kinds of records were kept. Time spent filling in the learners' record books is included under learner time. Time spent completing the clinical teacher's own record and the learner's kardex is entered as "records" time.
Travel	All time spent in moving from one work area to another, e.g. from college to hospital, from office to ward.
Waiting	This includes time spent checking ward duty rotas, rearranging learners' duties, finding an available learner or waiting for a learner to become available.
Progress	Time spent discussing learners' progress with other members of staff.
Planning	Time spent on the planning of the clinical teaching.
Business	Time spent on other business clearly related to clinical teaching which was not appropriately designated "progress" or "planning".
Correction	Time spent reading, marking or assessing learners' written work.
Social	Any interaction in which the topic was not specific to clinical teaching has been classed as "social" irrespective of its nature and of the other person involved. This includes time spent on seeking out and speaking to the person in charge of the ward on entering or leaving it. Where such an interaction was partly "social" and partly "business", "progress" or "planning" an attempt has been made to allocate the time accordingly.
Personal	Any activity which would not be accounted for under the other headings has been included as personal time. It mainly consists of coffee and tea breaks.

Although for the purposes of analysis it was necessary to identify the various types of activity and topic, in practice many conversations included several of these categories. It is possible, therefore, that in allocating time to the different segments of a conversation there may have been some over or under emphasis which will be most serious for those activities which occupy the least time in total.

Figure 10 Distribution of Clinical Teachers' time during observation periods : Trial Phase

figures were confirmed by the senior tutor and director, although the latter would have liked them to have done more -

> "I asked twice if any of them wanted to participate in classroom teaching and there was an emphatic no. Now, the clinical teachers changed eventually and I again put it to them a year ago and they said no. However, as a policy I think I'll be changing that ..."

There was little or no suggestion that any part of their work was not 'legitimate'. Although all three 'grumbled' about having to spend so much time at meetings at the college (e.g. a regular staff meeting, procedure committee, in connection with new schemes of training) they accepted that these were a necessary part of their work.

Presumably because the clinical teachers did not participate in classroom teaching to any great extent, there was very little overlap between their work and that of the tutors. The tutors' suggestions were mostly related to expanding the clinical aspects of the clinical teachers' work, for example, advising staff nurses on teaching methods, attending unit meetings, clinical assessments and participating in in-service training for trained staff. The clinical teachers themselves did not raise these subjects at all.

The organisation of clinical teaching

Compared with the clinical teachers who took part in the exploratory study (chapter two) a smaller proportion of *Anne*, *Joan* and *Karen's* time was spent on 'college work' and it consisted of a different range of activities. All three had been heavily involved in planning the clinical experience for the new training programme (6,7) and their other college activities seemed to some extent to be

directed by their specific expertise, for example, orientation of learners to their own fields of nursing, reviewing text books, organising and supervising experience for clinical teacher students, reading learners' care studies and helping with final revision for the students in their wards.

In each case their allocation of wards posed difficulties. They had to visit more than one hospital (e.g. the three geriatric units) or they had learners in a large number of wards (e.g. sixteen plus an outlying hospital) or they were allocated to several different types of clinical area (e.g. medical, and surgical wards, accident and emergency department and theatres).

Although these clinical teachers all worked college hours they said that they could see advantages in working with learners at weekends, during the evening and for at least part of the night shift. However ward staff receive extra payments for working these 'unsocial' hours and the clinical teachers were unwilling to work at these times without the same kind of extra payments being made to them. *Anne* commented that "the person at the health board who deals with these things" had indicated that these payments would not be possible, when she had been approached by the director. The director, however, said that the clinical teachers had refused to work at these times and that, although she had not yet approached the health board, she was sure that payment would be possible if it was in the learners' interest for the clinical teachers to work at these times.

The implementation of clinical teaching

One clinical teacher spent all of her teaching time giving tutorials to individual learners. The other two

divided their time between working with learners to give patient care, discussing aspects of their work with them and giving tutorials to one or more learners. (In this context a tutorial consisted of the clinical teacher withdrawing the learner to a side room where they sat and discussed a variety of topics.) They all tried to see each learner every week, although one amended this by simply "looking in on" her more specialised units (i.e. theatres and accident and emergency department) once a week, to speak to the staff rather than teaching in them.

The amount of planning which was done varied from deciding what to talk about on arrival at the ward to arranging teaching with the sister the day before. All of them seemed to have a number of standard topics which they discussed with all learners, varying the depth and presentation according to the learner and the circumstances. Particularly when the teaching was closely related to a patient in the ward, but even when it was not, all of the clinical teachers dealt with a variety of matters raised by the learners. Only occasionally did a learner appear to be unwilling to talk freely to a clinical teacher or to ask questions and initiate discussion. Whether this was due to the observer's presence or not it was not possible to tell.

The clinical teachers all seemed to have a fairly good relationship with most of the ward staff and said that this was something which they had to 'work at'. On two occasions the observer was aware of some tension in a ward but whether this was connected with the clinical teacher or not it was not possible to tell. On one occasion a clinical teacher cut short her time in a busy ward saying "I think sister's had enough."

Although they all liked the freedom which they had to arrange their own work, they all complained of being isolated and cut off from the college. While they visited the college building every week and had formal and informal contacts with tutors regularly they also complained that communication with the tutors was not good, giving the impression of being in a 'them and us' situation.

The clinical teachers completed clinical teaching records for each learner and were aware that the director looked at these from time to time. Apart from that they did not seem to be aware of any kind of monitoring or control of their work and implied that the tutors did not really understand what they were doing.

During the observations a number of potential sources of conflict were noted and these will be dealt with later. Grievances which the clinical teachers specifically mentioned were isolation, pay and relations with the college.

Attitudes

In different ways each of these clinical teachers suggested that although they derived a good deal of satisfaction from their teaching they found their position, part of both the wards and the college yet belonging to neither, both uncomfortable and frustrating. On the one hand

> "It's very difficult when you have a situation where there's no discord but there's not accord. .... It's not a good thing if you feel you're not part of the college."

This clinical teacher went on to say that to some extent the problems related to the college were part of the "awful muddle" in nurse education and in the training of nurse teachers. On the other hand

"it's the isolation and vulnerability of the situation that leads to dissatisfaction. .... should you be maintaining standards, complaining of standards, do you have influence over trained staff and their standards, or is it purely the students' and pupils' standards that you worry about, and if so how much onus can you put on the student to maintain standards if things are done differently in the ward? It's a very precarious position. You don't really belong to the service side. You have to accept an awful lot .. that I might not have accepted as a charge nurse but then I don't know the complete circumstances. There may be problems I don't know of."

Throughout the observations the observer was aware that much of the clinical teachers' activity could be seen by the ward staff as irritations or interference, while on many occasions what they did appeared to be dictated as much by the circumstances of the wards as by consideration of teaching method or optimum use of clinical teaching time and opportunities. It was these impressions combined with the data relating to the implementation of clinical teaching summarised above which gave rise to the suspicion that the actual role of any individual clinical teacher is determined by the organisational constraints to which she is subject which are external to clinical teaching and outwith the control of the clinical teacher.

The Main Phase

For the main phase it was decided to observe four clinical teachers from similar areas of two colleges of nursing - *i.e.* medical and surgical wards, for the equivalent of five working days each and to ask learners and trained staff in their wards to complete a questionnaire. (In the event it was not possible to observe the second surgical clinical teacher and only three were used for this phase.)

Like the trial phase, this phase was carried out concurrently with the historical study but it was not

written up until after the historical study was completed. At that stage it was possible to go back to the index cards and to the records of the observations to check if any data relevant in the light of the historical study had been missed. The analysis and presentation of this stage of the research, therefore were influenced by the results of the historical study.

Arranging the fieldwork

Again the colleges were chosen because of their geographical convenience. An approach was made to the Director of Nurse Education through the Chief Area Nursing Officer, setting out briefly the requirements of the fieldwork and inquiring if it would be possible to carry out part of the study in that college. The Director was given an indication of the time commitment for her clinical teachers herself and the tutors and this information was supported by a leaflet describing the fieldwork. In both cases the Director followed up the suggestion of a meeting to discuss the project and at that time information was obtained about the college, the numbers of clinical teachers and their allocations. A meeting was then arranged with the clinical teachers when a description of the research was given with a fuller discussion of what would be involved in the observations. Questions and comments were invited and discussed and the facts that data would be confidential and that participation should be voluntary were stressed. The remit of those willing to participate was discussed and the observer arranged to contact those who would be observed to discuss the details with them nearer the proposed time of observation. A letter was then sent to the Divisional Nursing Officer of the area in which the individual clinical teacher worked, referring to the original letter to the Chief Area Nursing Officer, telling her that arrangements were being made to work with the clinical teacher and asking permission to

invite ward staff to complete a questionnaire. A copy of the leaflet was included.

Before beginning observations two visits were paid to the hospital with the clinical teacher. The first of these was an orientation visit at a time suitable to the clinical teacher, usually late morning and including lunch. At this meeting an attempt was made to allay the clinical teacher's apprehension of being observed by stressing that the purpose of the exercise was to find out what the job was like and that it was in no sense an attempt to evaluate or make judgements about either the clinical teacher or any aspect of ward management or nursing care. Such details as times of observation, the importance of following as near normal as possible a routine, lunch arrangements, the explanation and introduction which would be made to learners, patients and staff and the procedure to be followed if the clinical teacher felt that the presence of a third person was disrupting her interaction with a learner or breaching confidentiality were discussed. The opportunity was also taken to meet ward sisters, nursing officers and any other people whom the clinical teacher thought necessary and to arrange a central collection point for the questionnaires. It was agreed that the clinical teacher would not allow the observations to prevent any changes to her programme which might be desirable and that she would leave an indication of her whereabouts in her office each day so that she could be easily found.

During this introductory visit it was sometimes possible to distribute some questionnaires for the trained staff otherwise this was done on the next visit to the wards. In most cases the learner questionnaires were distributed as the learners were first encountered. In all cases individuals were asked at a subsequent meeting if they had been given a questionnaire in order to remind them to

complete it. All questionnaires were accompanied by an envelope addressed to the observer at a central point e.g. the general office, the college of nursing or hospital reception.

The second preliminary visit was for a half day's observation - usually an afternoon. This was arranged for as soon after the orientation visit as possible and was intended to accustom the clinical teacher to being observed and to identify any problems.

Thereafter the clinical teacher was observed for the equivalent of one working week. The observation periods were variously spaced to accommodate other commitments of the observer and to avoid periods when the clinical teacher was not working 'normally' in the wards for example if the clinical teacher had occasion to teach in the college or went there on a regular basis e.g. one day a week, that time was not included in the observation periods.

All the clinical teachers, tutors and Directors were fully informed of the observer's position and interest in the subject as were senior hospital staff whose permission/approval was sought. The observer was introduced to all other staff as "from Dundee College of Technology. She's doing a research project about clinical teaching". If staff asked for more details the questions were answered truthfully and as fully as seemed appropriate but unsought information about the observer's nursing background or connections with clinical teaching was not volunteered.

College A served an area consisting of two medium sized towns and a number of rural communities. The college itself was situated on the site of one of its biggest hospitals in the larger of the two towns. There

were five senior tutors one of whom led the team to which both of the clinical teachers observed belonged. There were two other clinical teachers in this team. The team was based in the smaller town in the pupil training school for the district on the site of one of its hospitals. Both clinical teachers normally spent one day a week at this school and the rest of their time in other hospitals in the town. They seldom visited the main college which was about fifteen miles away.

Margaret was allocated to three general medical wards and a small intensive care unit situated in two separate buildings in a two hundred bed hospital dealing mainly with geriatric and medical patients. It also had an orthopaedic ward and a convalescent surgical ward which are not used for training. Two of the medical wards were situated in a new building. They were built to a 'modified race track' design with single, double and six bed bays on each side of a sitting room and service facilities. In both wards nurses were allocated to one side for a shift and the sides were worked independently. In the male ward one side had had the two- and one-bed bays and one nursing station turned into an intensive care unit which was staffed separately from the ward, although it was under the control of the ward sister. The third ward, which was used by the same physicians, was housed in the old building. It consisted of one long corridor with double rooms opening off one side. There was a sitting room at each end and the service facilities were in the central area. It was a mixed ward with men at one end and women at the other and was used mainly for investigations except in the summer when it took geriatric patients to allow the geriatric unit to accommodate holiday admissions. It also took longer term patients from the other two medical wards.

Students and pupils at all stages of training worked in all three wards but only pre-registration students doing a medical option worked in the intensive care unit.

Margaret carried a radio page and had her own office in the administrative/nurses home block which lay between the two ward blocks. She had not trained in the area and had worked as a health visitor for many years before deciding to return to hospital. She had been a clinical teacher for six years. Until her colleague was appointed two years previously the geriatric wards were included in her allocation and she had had a commitment to teaching in the school. She relinquished that commitment at her own request.

Susan was allocated to four wards in a 130 bed surgical hospital. The wards were female orthopaedic/gynaecology, male surgical, female surgical/gynaecology and a fourth ward was closed for rebuilding. She also "kept an eye on" learners in the male orthopaedic ward and in the paediatric ward, which was controlled by the sister of the orthopaedic/gynaecology ward. All of these wards were cubicled with most of their offices and service facilities situated at or near the entrance.

The hospital was approved for the training of students and pupils. Pupils were allocated throughout their two years and students during their first year only unless they were doing a surgical option when they spent their last six months there.

Susan carried a radio page and had her own office in the nurses' home which was used mainly for offices and changing accommodation. She had trained in the hospital and had worked there as theatre sister and night sister prior to becoming a clinical teacher six years previously.

College B was a large training school in a city. It was situated on the site of the largest of its associated hospitals, the majority of the other hospitals being within the city. There were five senior tutors of whom two were concerned with general training. Although the clinical teachers were assigned to the senior tutors' teams this seemed to be for the administration of classes only as the clinical teaching affairs and policy were the responsibility of the assistant director who met the clinical teachers on a regular, though not very frequent, basis.

There were six general clinical teachers based at the college and working in the main hospital. This was a large acute general hospital which housed a number of specialist medical services for the region. The clinical teachers shared three offices within the college which was in the nurses' home building. Morning coffee breaks were taken in the senior staff canteen, afternoon tea in the senior nurses' common room in the nurses' home and most of the clinical teachers took a sandwich lunch in one or other of their offices, usually congregating in the largest office at least for a few minutes at this time.

There were four medical wards, all in the old part of the hospital which was being up-graded. One of these wards was within the remit of the paediatric clinical teacher, the other three formed the whole allocation of *Agnes*. One ward was on the ground floor, the other two adjoined each other on the second floor. All of the wards were designed in a series of medium sized and small rooms, offices and service areas which opened off a main corridor, (some also connected with each other) but in one ward this pattern had been modified to provide a coronary care unit which was geographically within the ward area but was staffed separately and was not part of *Agnes'* allocation. Student nurses were allocated to the wards

throughout their training but pupil nurses were not.

Agnes had not trained at the hospital, she joined the staff immediately after completing the clinical teachers course and had been a clinical teacher for six months.

The questionnaires which had been developed during the first exploratory study provided the basis for a somewhat more detailed closed questionnaire which sought to elicit what the respondent thought 'ought' to be the case, and her perception of what was the case. The clinical teachers, the directors of nurse education and the senior tutors concerned were interviewed. The schedule used for these interviews was also based on that used for the first study but was much more flexible and open, allowing for more discussion of aspects of the subject raised by respondents or topics suggested by the observations. The clinical teachers were interviewed at the beginning of the observation periods and subsequently many of the topics were raised again in informal discussion in the course of the observations, the other staff were interviewd after or towards the end of the observation periods.

Findings from the Main Phase

The broad framework within which these clinical teachers worked was very similar to that described in the trial phase on pp 211-213. That description will therefore not be repeated but a number of variations will be described. Although during the observation periods both *Margaret* and *Susan* worked from 8.30 a.m. to 4.30 p.m. they said that they would work at other times if the learners particularly needed them to do so. They declared this to be accepted practice in the college although the impression given was that they did not do it very often. *Agnes* also usually worked college hours but for her own convenience was trying to arrange to work from 8 a.m. to 5 p.m., periodically taking time off in lieu of the extra daily hour.

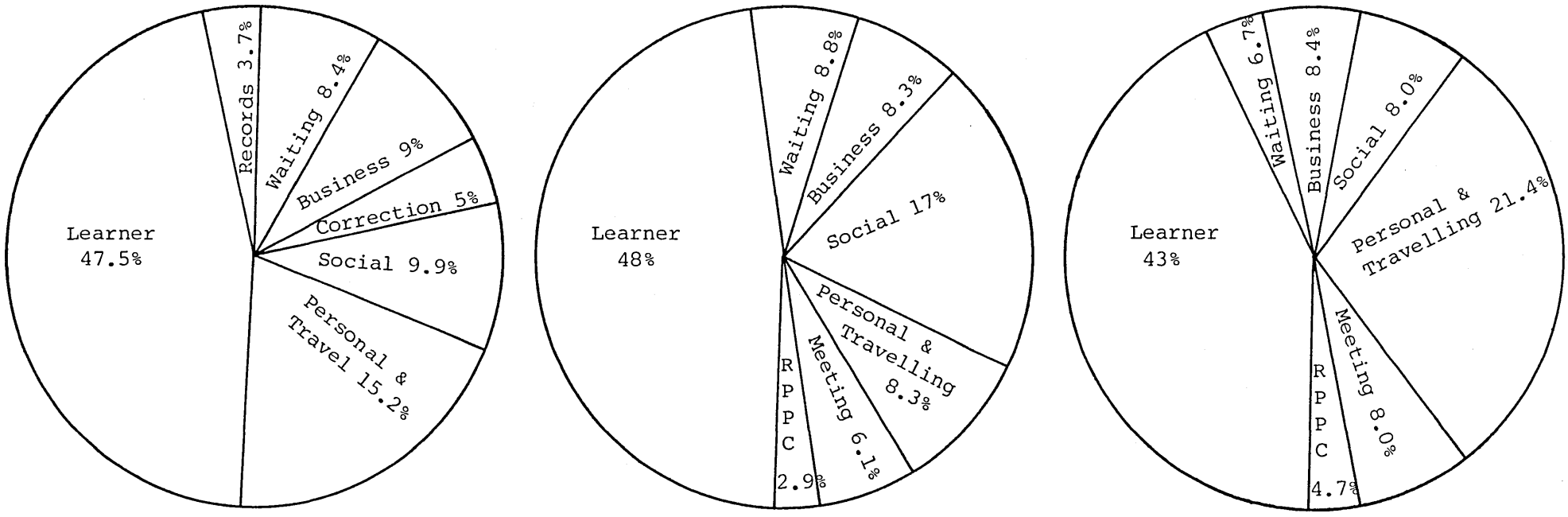
She did in fact work these hours on most of the days when she was being observed but the indications were that she would not be able to make this a permanent arrangement as it could not be justified by the needs of the learners. Several of her colleagues however did work in the evenings or at weekends from time to time to fit in with learners' duty rotas. *Susan* had lunch in the staff dining room because it gave her the opportunity to meet other members of staff informally, the other two had sandwiches in their offices. Both *Susan* and *Margaret* were normally or frequently on their own at lunchtime and tended to use some of the time to complete records, read journals or prepare for the afternoon's work. *Agnes* also used some of the time in this way but she met other clinical teachers and spent time 'chatting' to them. She also had the opportunity for this kind of informal contact with her fellows at coffee and tea breaks. All three obtained a note of their learners' duty rotas at the end of the previous week, or at the latest by Monday morning. Both *Margaret* and *Susan* had set days for visiting each of their wards although *Susan* did not seem to adhere to this arrangement in the afternoons. All of them had a rough idea of which learner they wanted to see and what they wanted to do with them before they went to the wards but they varied considerably as to the extent to which these plans were put into practice. The reasons for not carrying out their plans varied, the most common being that the learner was not available and that the ward sister had asked the clinical teacher to work with someone else - either because the second learner seemed to need help or because she wanted to deploy the original learner differently e.g. send her on ambulance duty. Both *Margaret* and *Susan* sometimes arranged their teaching with the nurse in charge beforehand but *Agnes* only did this in one ward. She felt that the learners either got "up tight" if they knew that

she was coming or were disappointed if she arranged it and then did not appear. In one ward the sister liked to know in advance. All three tended to work with their learners doing whatever work had been allocated to the learners in the mornings and then to take the same or different learners for "tutorials" in the afternoons. Although they all claimed that they discussed the care that they and the learners had been giving together in the morning during the afternoon tutorials, on the occasions when the observer was present they as often discussed other topics instead or as well. All three were seen to join nursing staff for nursing reports on occasion and all consulted the nursing kardex and medical records of patients freely.

The broad similarity amongst these clinical teachers which is emphasised by the pie charts (figure 11) showing the breakdown of the time during which they were observed, masks some very real differences which are identified when the data from the observations and the interviews are coded and analysed using the framework.

The way in which the job is conceived and/or defined

Susan was the only one who did classroom teaching regularly and that was confined to one week of classes at the beginning of each six month surgical option for pre-registration students. However, both *Susan* and *Margaret* were heavily involved with the supervision and assessment of the students' projects and care studies. Both *Susan* and *Margaret* normally spent one full day in the school when they completed learners records, met with their senior tutor and did their own preparation. The observer did not accompany them on these days and they were both somewhat vague about how the time was used. Both complained that it reduced their ward time greatly and both sometimes arranged to see learners in the wards on that day.



RPPC = records, planning, progress, correction and preparation

For further legend and explanatory notes see figure 10 (page 216)

Figure 11 Distribution of clinical teachers' time during observation periods : main phase

The organisation of clinical teaching

Each of the clinical teachers identified problems with their allocation of wards although they were all geographically compact and required no travelling.

Margaret indicated that she had had problems at first because she had been out of acute medicine for so long. She implied that these problems had been resolved except sometimes in relation to the intensive care unit, but the observer got the impression that she was not very happy dealing with the more technical aspects of the nursing care.

Susan had the most varied allocation. She did not teach specialist paediatrics or orthopaedics and was happiest dealing with the gynaecological nursing.

Agnes complained that three wards were too much and said that she would prefer to be attached to one ward so that she could work as a member of the staff and would really know the patients. All of her wards practised patient allocation to the extent that the learners were assigned to rooms and *Agnes* and her learner usually spent the whole morning in one room carrying out all the care that those patients required. *Agnes* spent more time than the others 'chatting' to patients as opposed to talking to them while carrying out care.

The implementation of clinical teaching

All three divided their time between working with learners to give patient care, discussing their work with them and giving tutorials to one or more learners.

Although each of them ostensibly planned what they were going to do and with whom beforehand what they actually did seemed to be largely determined by the way in which the ward sister allocated the work to learners.

In most cases the pattern of work was fairly fixed - bedbathing, getting patients up, preparation for theatre - but because of the variety of patients and the different stages of training of the learners there was potentially a considerable choice of teaching material. There was also great potential for interruptions both from the other patients in the bay or room and from external sources. Of the three *Margaret* seemed to follow her plan most closely and this included having a number of set topics for the tutorials which she related to patients in the ward. Her time was most tightly organised of the three.

Susan tended to work with the learners less and to watch them more as they worked. She often gave tutorials in the mornings as well as the afternoons and covered more ground at a time. She did not keep to her plans very rigidly and frequently gave the impression of being unsure of what to do next. *Agnes* spent most mornings carrying out care with her learner and during this time did very little formal teaching, tending to 'flit about' from one topic to another as they were raised in connection with the care which she and her learner were giving. In conversation with the observer she stressed the need to relate her teaching to the work the learner was doing but seemed to be worried by the resulting pattern of teaching. She also expressed concern that it was not possible to see that learners did things the way that they were taught in the college because of lack of equipment or space or because it did not seem to be very practical.

Attitudes

Although all three clinical teachers seemed to have good relationships with their ward sisters they differed greatly in their attitude to them and to the staff nurses.

Margaret displayed a somewhat anxious and apologetic diffidence, while *Agnes* gave the impression of fitting into the nursing team somewhere between the sister and the staff nurses. She was noticed on several occasions to make nursing decisions about a patient's care and either carry them out herself or suggest them to sister or a staff nurse. On these occasions she appeared to be acting as she would have done had she actually been a member of the ward staff and her actions were apparently acceptable to the staff. *Susan* was also seen to initiate nursing care on one occasion and this was in marked contrast to *Margaret* who referred every decision to the nurse in charge of the ward. Both *Susan* and *Agnes* were asked about their reaction to this kind of decision making. *Susan* indicated that she tried to make decisions which were consistent with the stage of training of the learner with whom she was working. *Agnes* seemed to relate these decisions to her own expertise as a nurse. "Once they (the ward staff) know that they can trust you, they don't mind". The staff nurses who were asked about this seemed to agree with *Agnes*; by contrast, the tutors and directors were all of the opinion that clinical teachers should not be making nursing decisions but should refer everything to the nurse in charge.

Of the three, *Agnes* seemed to be the most satisfied. Both *Susan* and *Margaret* gave the impression of feeling that they were rather isolated from their teaching colleagues and from the rest of the hospital staff. *Agnes* did not seem to have much contact with the tutors but had frequent contacts with other clinical teachers.

The Questionnaires

Because this study is directed primarily to the exploration of conceptual and methodological issues, quantitative data are relatively less important.

The questionnaires (appendix 5), which were based on the categories which emerged from the earlier stages of the study (pages 47, 171), were designed to elicit information about the ways in which the various groups perceived the clinical teaching which they were experiencing, and about how they would have liked it to be implemented. Each group of responses, therefore, has to be considered in the context of an individual clinical teacher's pattern of work so that any marked differences between or amongst the groups can be identified. In the analysis which follows the questionnaires from each clinical teacher's 'role set' are considered separately and the categories which emerged from the historical study are used in their analysis. Where it seems appropriate the data are summarised but, to reduce the amount of interruption in the text, the summaries have not been treated as tables and are not individually numbered or labelled. In each case 'Y' stands for 'yes', 'N' stands for 'no', '?' stands for 'unsure' and 'P' represents the number of possible responses for that item.

Before completing the questionnaires several of the learners asked the clinical teachers if it was "all right" to do so and gave them the impression that they thought that their answers might in some way be used "against" the clinical teachers. It is possible, therefore, and perhaps likely, that they give a more favourable impression than was warranted. Trained staff had more opportunity to ask about the study than did learners, and were, in any case, less likely to anticipate immediate repercussions for the clinical teacher. Nevertheless, they, too, may well have tended to give an unduly favourable impression of their own contribution to clinical teaching and of their opinion of it. For these reasons and because the numbers are small, all of the material from the questionnaires must be treated with caution, especially in attempting

to derive any quantitative conclusions. In two of the hospitals, two thirds of the questionnaires in each group were returned but in the third hospital there was a very poor return. One member of staff suggested that this was because they were "always being asked to fill up questionnaires." In that hospital only the trained staff questionnaire was returned in sufficient numbers to analyse (8 out of 10). As a result no figures for learners or tutors are given for *Agnes*, while *Margaret* and *Susan* each have a group of learners and of trained staff and share the same group of tutors. The number of possible answers in each case is a product of the number of questions relating to the topic and the number of questionnaires. However, because some respondents did not answer every question the number of actual answers does not always tally with the number of possible answers.

Experience

The historical prescriptions differ about the amount of nursing experience which is necessary for a clinical teacher. One suggests that clinical teachers should be experienced ward sisters and the other that clinical teaching should be a training post for staff nurses.

Margaret who had been a clinical teacher for six years, had had some experience as a ward sister, but this was prior to health visiting and to marriage and a break in service. Her experience immediately before becoming a clinical teacher was as a staff nurse in a different field from that of her clinical teaching allocation.

She and almost all of her role set said that a clinical teacher should be a very experienced nurse. There was considerable difference of opinion, however, about the need for ward sister experience, the tutors being most convinced of the need for this kind of experience and the learners being the least sure. This difference could be due to the learners' limited experience of the clinical teacher's job, but equally the tutors may have been influenced by the desire to ensure a high status for nurse teaching generally.

	C.T.			Tutors				Trained staff				Learners			
Margaret	Y	?	N	Y	?	N	P	Y	?	N	P	Y	?	N	P
experienced nurses?	1			7			7	8	1		9	5	1	1	7
ward sister experience?	1			5	2		7	6		3	9	1	1	5	7

Susan had trained in the hospital and held theatre and night sister posts there prior to becoming a clinical teacher. She had been in post for six and a half years.

She and almost all of her role set said that a clinical teacher should be a very experienced nurse. There was some difference of opinion, however, about the need for ward sister experience, the learners being the most ambivalent about it.

	C.T.			Tutors				Trained Staff				Learners			
Susan	Y	?	N	Y	?	N	P	Y	?	N	P	Y	?	N	P
experienced nurses?	1			7			7	15	2		17	9	1		10
ward sister experience?	1			5	2		7	13		4	17	4	2	4	10

Agnes had worked for three years as a ward sister in the same field in another hospital and had come to this hospital on completion of the clinical teachers course. She did not think that clinical teachers needed to be very experienced or to have had ward sister experience although all but two of 'her' trained staff did think so.

	C.T.			Trained Staff			
Agnes	Y	?	N	Y	?	N	P
experienced nurses?			1	7	1		8
ward sister experience?			1	6	1	1	8

Type of teaching

The next two statements were designed to give an indication of whether the clinical teacher was expected to work with the learner in giving patient care or simply to 'tell them about it' in tutorials. They are presented in the form of opposites, and respondents who were being consistent in their reactions to the statements might be expected to agree with one and disagree with the other. *Margaret* and *Susan* and the ward sisters did show this consistency while on the whole the learners and the tutors and *Agnes* did not. (see page 238)

The results are interesting in that while *Agnes* and the tutors seemed to see clinical teaching as having a large practical element, *Margaret* and *Susan*, the trained staff and the learners either do not or are unsure, being much more accepting of the clinical teacher as one who gives tutorials rather than working with learners. To what extent this result is influenced by current practice it was not possible to say. *Margaret* and *Agnes* spent most mornings giving care with learners and most afternoons giving tutorials. *Susan* spent more of her time giving tutorials and sometimes seemed to imply that working with learners was more important as a way of obtaining tutorial time than as a vehicle for teaching. This idea of an 'exchange' between the ward staff and the clinical teacher ("I will contribute to the work of the ward by working with learners if you will let me 'take them away' for tutorials later") was implied by all of the clinical teachers observed except *Joan* in the trial phase, although some seemed to attach less importance to it than others.

	C.T.			Tutors				Trained Staff				Learners			
Margaret	Y	?	N	Y	?	N	P	Y	?	N	P	Y	?	N	P
Clinical teachers should not as a rule be taking learners away from the bedside to give them tutorials	1			6	1		7	2		7	9	-		7	7
It is unrealistic to expect a clinical teacher to spend most of her time giving patient care with learners			1	2	2	3	7	7		1	9	1	2	4	9
Susan															
Clinical teachers should not as a rule be taking learners away from the bedside to give them tutorials			1	6	1		7	9		8	18	4	3	4	11
It is unrealistic to expect a clinical teacher to spend most of her time giving patient care with learners	1			2	2	3	7	7	3	8	18	1	2	8	11
Agnes															
Clinical teachers should not as a rule be taking learners away from the bedside to give them tutorials			1					3		4	7				
It is unrealistic to expect a clinical teacher to spend most of her time giving patient care with learners			1					3		3	7				

Planning

The second prescription specified that the clinical teacher should provide regular, planned teaching. Planning is not mentioned in the first prescription.

Margaret subscribed to the view that she should plan her teaching to the extent that she did make out a plan for herself for the week which included the names of the learners with whom she wanted to work each day and an indication of the kind of teaching which she would like to give them. She did not, however, tell the learners of her plans. She usually worked in each ward on a set day each week but did not arrange her exact programme of teaching with the trained staff of the ward until the morning of that day or, very occasionally the previous evening. She was at pains to assure the observer that although planning was important it had to be flexible enough to accommodate the frequent changes necessitated by unavailability of learners caused by, for example, ambulance duty or absence, and the constraints of the ward work which might result in her working with a different learner or doing a different range of tasks or kind of teaching from that which she had intended. The overall impression was that she considered planning to be necessary for her own benefit to give her week a basic structure but that it was seldom possible to implement the plan in detail and that it was not, therefore advisable to share it with ward staff or learners until the last minute. Although this clinical teacher said that it was not realistic to plan her teaching with ward staff she was sometimes seen to do this albeit in a fairly general way e.g. I'll try to do that tomorrow or next week" rather than making specific arrangements to be in the ward at a certain time.

The learners and trained staff did not altogether agree with this clinical teacher's practice. Although the learners did not admit to being unsettled by her unexpected arrival they said that they would prefer to know beforehand that she intended to work with them and they almost all said that she should plan her teaching ahead with the ward staff or at least let them know what her plans were, although they too thought that it would be difficult to adhere to a rigid plan given the ward setting.

The trained staff were much more sure that it is possible to plan ahead and they were strongly of the opinion that it should be done. The results from the tutors questionnaires were almost identical with those from trained staff.

Margaret	C.T.				Tutors				Trained Staff				Learners			
Planning	Y	?	N	P	Y	?	N	P	Y	?	N	P	Y	?	N	P
desirable?	3		1	4	16	3	2	21	22	2	3	27	23	1	10	35
feasible?	1			1	12	1	1	14	13	2	3	18	2	3	2	7
happens?	3			3	7	9	3	21	15	11	1	27	6	6	9	21

Ward staff not only put considerable weight on planning but also seemed to think that they should be more involved in it, and that it was much more possible than the clinical teacher believed.

Susan went round her wards at the end of the week and copied the learners off duty into her notebook. She therefore knew who should be on duty in which ward each day of the week. She usually worked in each ward on a set day, e.g. their theatre days, but might vary this arrangement in the afternoons. When asked whether it was possible to plan a whole day's teaching in advance she said "The few days I do manage it, it's lovely, but

I find that there's an awful lot of intrusions." and then went on to explain why it was impossible. She said that when she did plan to see a particular learner she arranged it with the nurse in charge of the ward and told the learner when she would be arriving in the ward and what she wanted to discuss with her if that had been decided. She was seen to do this on one occasion but more often seemed to arrive in the ward with the intention of seeing what the learners were doing before deciding what to teach or who to take.

Both learners and trained staff expressed the desire for a planned programme and this was particularly so for trained staff, half of whom said they would like to see more planning of the clinical teaching, both in the sense of having a regular pattern of going to the wards and in the sense that she should plan her teaching with the ward staff.

Susan	C.T.				Tutors				Trained Staff				Learners			
Planning	Y	?	N	P	Y	?	N	P	Y	?	N	P	Y	?	N	P
desirable?	3	1		4	16	3	2	21	44	3	3	54	37		14	55
possible?	1		1	2	12	1	1	14	21	5	8	36	3	3	4	11
happens?	1	1	1	3	6	9	3	21	15	13	8	54	4	24	4	33

In *Agnes'* hospital off duty rotas were made up for two or three weeks at a time and she usually made up a two week plan of which learners she would see and when. The pattern of patient allocation adopted by the wards and her method of working with one learner for a whole morning, helping her and supervising her in her allocated work, meant that it was usually possible to keep to the plan, although she stressed the need to be 'flexible' and to respond to requests for help/information from other learners in the ward. The custom in the hospital was

that clinical teachers should mark the ward off duty sheet at the time and name of the nurse with whom they intended to work, but *Agnes* said that she often did not do this because the learners became anxious about her visits. She was rather vague as to whether the sisters knew of her plans for their staff. The closed questions showed considerable support for the idea that planning was desirable and possible and they suggested that some planning did take place. In the open questions one sister commented that she would like to know when the clinical teacher was coming and what she intended to do and one staff nurse said that it would be better to arrange the teaching when she arrived rather than to have decided beforehand.

Agnes	C.T.				Trained Staff			
Planning	Y	?	N	P	Y	?	N	P
desirable?	2		2	4	14		7	21
possible?	1			1	12	1	1	14
happens?	3			3	14	1	6	21

Relationship with ward staff

The difference of opinion about the planning of clinical teaching raises the whole question of the clinical teacher's relationship with the trained staff of the wards and with the ward sister in particular. As we have seen, the early writers on this subject were at pains to stress the need for co-operation and the fact that the clinical teacher would not usurp the ward sister's authority in the ward or take over her teaching responsibilities. She was to supplement the teaching already being done by the ward staff, indeed the first prescription suggests that she should assist the ward sister with her teaching.

The relationship of the clinical teacher to the ward staff can be considered under four headings

1) the extent to which the ward staff cooperated to make the clinical teacher's job easier or more difficult by making available the learners and by providing the information which she needed.

2) the relationship between the teaching which the ward staff do and that of the clinical teacher.

3) the extent to which the clinical teacher is perceived to be a part of the ward/hospital or an external agent.

4) the extent to which the clinical teacher creates a separate locus of authority in the ward or works within the authority of the ward sister. (This need not imply that the ward sister determines or controls her teaching)

Extent of ward staff's cooperation

In response to the questionnaire *Margaret* said that she fitted into the ward sister's allocation of work, but only half of the trained staff and two thirds of the learners thought so, although, in spite of this, they strongly denied that her activities interrupted the ward work too much and only one person thought that she interfered with the organisation of the ward.

Susan strongly denied that she just fitted into the ward sister's allocation of work, but two thirds of the trained staff and three quarters of the learners thought that she did. The great majority denied that she interrupted the ward work too much and only five trained staff and one learner said that she interfered with the organisation of the ward.

Agnes also strongly denied that she just fitted into the ward sister's allocation of work but half of her trained staff thought that she did so. None of them thought that

she interfered with the organisation of the ward but two of the eight did think that she interrupted the work too much.

Further light was shed on this during the observation periods when considerable rearrangement of duties to accommodate *Margaret* was noted at times. Since this clinical teacher usually worked with a learner in carrying out the work which had been allocated to her this rearrangement usually meant redeployment of the person originally nominated to work with that learner, so that, although the clinical teacher accomplished less work with the learner than could have been done had there been no teaching, her presence might, and often was, a considerable help. This is borne out by the positive response given to the statement "it is good to have a clinical teacher in the ward when we are very busy." (Only two of the nine trained staff and two of the seven learners disagreeing.)

During observation periods *Susan* was seen, more often than not, to join the learners in carrying out the care that had been assigned to them. Duties were seldom rearranged to accommodate her, although she often worked with the learners and would, therefore, be taking the place of another member of staff, redeployment was not often noticeable.

Asked to respond to the statement "it is good to have a clinical teacher in the ward when we are very busy" twelve of the trained staff and two learners agreed while six trained staff and seven learners disagreed.

During observation periods, *Agnes* usually spent the mornings working with a learner who had been assigned to care for all the patients in one room. Duties seldom seemed to be rearranged to accommodate her, perhaps partly

because the learner would have been assigned to these patients anyway and partly because the trained staff often knew to expect her. However only three of the trained staff said that it was good to have the clinical teacher in the ward when it was busy. (Two were unsure and the other three disagreed.)

Another aspect of the reallocation of duties was the way in which the rest of the staff sheltered *Margaret* and her learner from interruptions caused, for example, by requests from patients other than those with whom they were working, the telephone or the needs of various kinds of visitors to the ward. Most of the time this sheltering seemed to result from a tacit assumption by all concerned that the clinical teacher and her learner would not respond to bells or call-system buzzers and that they would pass on all but the most easily satisfied requests to other members of staff, but occasionally it became more explicit when someone was asked by the nurse-in-charge to take responsibility for such an interruption.

It is particularly interesting that neither the staff nor the clinical teacher appeared to be aware of the extent of this sheltering, nor was there any suggestion that ward staff felt themselves to be inconvenienced by the way in which they accommodated the clinical teacher.

Susan and *Agnes* did not appear to be sheltered from interruptions to the same extent as *Margaret*. Indeed they were interrupted a great deal. This may have been partly due to the different layout of the ward, but was also partly self inflicted, since they readily answered the telephone if they happened to be nearest to it and also tended to speak to patients and staff in passing.

Margaret indicated on several occasions that she had to handle ward staff with care and that she did not feel free to discuss ward practices with them. Some of her

apparent insecurity in relation to this might have been due to her relative unfamiliarity with the wards in which she worked only once or twice a week. During observation periods she did not take the initiative for patient care, referring to the staff nurse or sister for instructions even when she had worked with the same patient the day before and might therefore have assumed knowledge of the nursing care.

Observation with this clinical teacher revealed no occasion which might be construed as her interfering with the organisation of the ward.

Susan seemed to feel quite free to discuss ward practices with ward staff. Unlike *Margaret* she had trained in the hospital and was one of its longest serving members of staff. She had trained with some of the sisters and many of the staff nurses had themselves been her students in the recent past. During observation periods they appeared to be happy to discuss ward practices with her.

Observation revealed one occasion when *Susan* decided that a patient needed specific intervention and went to sister and offered to arrange it. Sister accepted the offer and seemed to accept the clinical teacher's initiative as right and proper.

Agnes also seemed to feel free to discuss ward practices with the trained staff although she appeared to be more comfortable with the staff nurses than with the sisters. Observation revealed several occasions on which she initiated a change in nursing care or approached medical staff about a patient. The trained staff with whom the observer discussed this seemed to accept it as right and proper since she always told them what she had done but in the open questions one staff nurse said that

she thought that clinical teachers should not 'interfere in the ward routine' and one sister said that they should not alter treatment without first consulting the ward staff. Interestingly she gave as her reason "To save confusing the nurse learners".

Data about the way in which the clinical teacher obtained information come from the questionnaires and from observation. *Margaret* claimed that she did not have difficulty in getting the information which she needed, and in two of her three wards the ward sister was seen to spend some time giving her a report and telling her about new admissions. She was also invited on one occasion to join the ward staff for a report. (In the third ward a new sister took up her appointment on the week of the observations and the normal pattern was therefore disrupted, but the impression gained from the interaction of the clinical teacher with the staff nurses on that ward was that it had been much the same as on the other wards.) In addition to this the clinical teacher frequently asked trained staff for information and consulted the patients' records.

Susan consulted the nursing kardex and the medical records of patients freely and said that if there was anything "that's unusual" or "isn't just self-explanatory" she asked the trained staff and she was seen to do this. She was never seen to join the ward staff for a report, nor did she mention this as a source of information about patients.

Agnes also consulted medical and nursing records freely and she was also seen to receive reports from the sister about the patients for whom her learner was responsible during the morning and to join the rest of the staff for other nursing reports to which she contributed freely.

When it was suggested to the trained staff and learners that the trained staff always made a point of telling the clinical teacher what was going on in the ward there was some difference of opinion amongst them as the following overview (where 5 = strongly agree; 4 = agree; 3 = unsure; 2 = disagree and 1 = strongly disagree) shows:

Margaret	5	4	3	2	1
ward sisters	1	1			
staff nurses	1	1		1	
enrolled nurses	1		1	2	
students			2	2	
pupils		2	1		

Susan	5	4	3	2	1
ward sisters		1	1		
staff nurses		3	4	1	
enrolled nurses		4	1	2	
students			6	3	
pupils				1	

Agnes	5	4	3	2	1
ward sisters		1		1	
staff nurses		1	2	3	

Information about learners' progress tended to be couched in fairly general terms, but on several occasions a ward sister made a point of discussing the needs of specific learners with a clinical teacher. This sometimes resulted in the clinical teacher arranging to work with that learner at the time to deal with specific topics, or during the rest of her stay in that ward to give more general support and supervision. The learners seemed to be unaware that their progress was discussed in this way.

The relationship between the clinical teacher's teaching and that of the trained staff

The historically derived prescriptions of clinical teaching stressed that the clinical teacher should supplement rather than supplant the teaching done by the ward sister and this suggests that each should know what teaching the other is doing and that they should share the teaching between them. While all grades accepted this principle there was considerable variation in their opinion as to what actually happened with the learners being much less convinced than the trained staff.

		Trained				Learner			
		Y	?	N	P	Y	?	N	P
The trained staff don't teach so much if there is a clinical teacher attached to the ward.	*Margaret*	1		8	9	1	1	5	7
	Susan		1	17	18	4	2	5	11
	Agnes	2		6	8				
The clinical teacher and the trained staff share the ward teaching between them.	*Margaret*	5	3	1	9	2	2	3	7
	Susan	4	4	10	18	3	3	5	11
	Agnes	1	1	6	8				
The trained staff tell the clinical teacher what they have been telling/showing the learners.	*Margaret*	6	2	1	9	4	6	4	14
	Susan	8	4	6	18	2	5	4	11
	Agnes	1	3	4	8				
The clinical teacher does not seem to know what the trained staff have been telling me.	*Margaret*					2	1	4	7
	Susan					6	2	2	11

Extent to which clinical teacher is perceived to be part of the ward staff

In order to gain an impression of the extent to which the clinical teacher is perceived to belong to the wards/hospital or to be an external agent, respondents were asked to consider a number of statements describing her orientation and contacts with hospital staff and patients.

Margaret was in no doubt that she belonged to the wards rather than to the college of nursing and that, although no longer formally part of a ward team, she still had satisfying contacts with patients and staff, including medical staff. *Susan* was much less certain about both of these aspects while *Agnes* claimed to have satisfying contacts with patients and staff but was uncertain of whether she belonged to the college more than the hospital since she gave conflicting answers to these opposite questions.

The tutors were only asked to respond to the statements about whether clinical teachers belong to the college rather than to the wards and they were divided in their opinions about this. Divided in that all the options were chosen and in that the same tutors gave conflicting answers to the two reversed questions suggesting that they were not clear about where the clinical teachers allegience should or does lie, although they were unanimous in rejecting the suggestion that clinical teachers do not work as a part of the teaching team. When it was suggested that clinical teachers are not well thought of by ward staff the tutors were again divided, *Margaret's* learners agreed and *Susan's* were unsure. The majority of trained staff and *Margaret's* learners disagreed that clinical teachers were not well thought of by tutors and *Susan's* learners were again unsure. The learners nearly all agreed that some of the clinical teachers seemed to know some of the tutors very well.

The impression given in this section, then, is that the clinical teacher affiliates, and is seen by trained staff and learners to be affiliated, with the wards but that the tutors tend to be ambivalent about this. Whatever tensions there may be between tutors or trained staff and the clinical teacher the learners are relatively unaware of it. This is particularly so with respect to the tutors and could be explained by the fact that the learners are less often in the college than in the wards and therefore see clinical teachers and tutors working together less often than they do trained staff and clinical teachers.

The clinical teacher as a separate locus of authority

In the early days of clinical teaching the clinical teacher might have been controlled either from the nursing administration office or by the college of nursing, but they are now formally part of the college staff and are usually directly responsible to a senior tutor. Their standing as college staff working in the wards provides a potential source of conflict with the ward sister as the fact that they are controlled by the college but may be separated from it in their work and orientation does with the tutors. A number of statements in the clinical teacher's questionnaire were designed to explore her perception of her autonomy or lack of it and other staff were asked whether or not they thought that she posed a challenge to the ward sister by interfering in the organisation of the ward. These matters were also explored in the interviews.

Margaret and *Agnes* strongly opposed suggestions that their work was controlled by the college and indicated that they had freedom to control their own work and to use their initiative. By contrast *Susan* was much more

aware of constraints imposed by the college. Although they 'handled the sisters carefully' they did not feel themselves to be unduly constrained by them or that their way of working was dictated by them.

Observation of *Margaret* and *Susan* revealed no occasion which could be construed as a challenge to the ward sister's authority in the ward or as interference in the organisation of the ward, with the possible exception of the redeployment of staff an enrolled nurse in the case of *Margaret* and *Susan's* initiative reported on page 232. Most learners and trained staff disagreed with the suggestion that they did interfere and casual conversation with trained staff during the observation periods gave the observer the impression that trained staff were glad to have the clinical teachers or at least did not see them as intruders.

As indicated on page 232 *Agnes* did at times assume a responsibility for patient care which both *Margaret* and *Susan* claimed they did not have. Both Directors and the senior tutors were asked about this kind of responsibility and all were reluctant to admit that it would ever be legitimate for a clinical teacher although when they were pressed with specific hypothetical examples they readily agreed that a clinical teacher who had been a ward sister and who was in any case a competent nurse might experience considerable role conflict. They were nevertheless adamant that all but the most routine of decisions about patient care should be referred to a trained member of the ward staff or to the nurse in charge even if that person was herself still a student.

Conclusion

The observational study, then, gave a great deal of information about the pattern of work of the clinical teachers involved and the ways in which they regarded their work. It also gave some indications of the constraints within which they worked, including the ways in which the ward staff, learners and tutors regarded clinical teaching.

Even within the same college of nursing there were considerable differences in the kind of remit which had been given to the clinical teachers. That is to say, in the proportion of time which they were expected to give to 'college work' of various kinds, including teaching, in the amount of involvement they had with such things as the supervision of learners' care studies, or revision for written examinations, and in what might be called administration related to clinical teaching, including providing liaison between the staff of the college and the hospital.

There were also marked differences in the kind of allocation which the clinical teachers had - the number of hospitals which they had to visit, the number and type of wards and the numbers of learners whom they were expected to teach.

Although there was a superficial similarity in their implementation of clinical teaching there were considerable differences in the ways in which they used the time which they spent with learners and in the proportion of their time which was given to other activities.

The data suggest three factors which may have considerable bearing on these differences -

- the orientation of the Director or college as it is reflected in the remit given to the clinical teachers e.g. the amount of 'classroom based' teaching which they are expected to do and the number of their non-clinical responsibilities, the number and spread of their wards, the specialties of the wards and the number of learners working in them.

- the clinical teacher's own perceptions of clinical teaching and her method of working e.g. whether she centres her teaching on patients or on procedures, the emphasis she puts on working with, supervising, or giving tutorials to learners.

- the circumstances of the ward and the way in which it and the learners' time are organised by the ward sister.

References for chapter seven

1. Goddard H.A. (1958) Principles of Administration Applied to Nursing Service W.H.O. Monograph Series No 41 W.H.O. Geneva

2. Becker H.S. (1971) Sociological Work; Method and Substance Allen Lane London

3. Pearsall M. (1965) Participant Observation as Role and Method in Behavioural Research Nursing Research 14:1 (Jan Feb) pp 37-42

4. Byerly E.L. (1969) The Nurse Researcher as Participant Observer in a Nursing Setting Nursing Research 18:3 (May June)

5. Robertson C.M. (1982) A Description of Participant Observation of Clinical Teaching Journal of Advanced Nursing 7:6(Nov-Dec) pp 549-554

6. General Nursing Council for Scotland (1978) Schemes of Training for the Register of Nurses G.N.C. Edinburgh

7. General Nursing Council for Scotland (1979) Training for the Roll of Nurses G.N.C. Edinburgh

PART FOUR

A TENTATIVE THEORY

CHAPTER EIGHT

THE IMPLEMENTATION OF CLINICAL TEACHING

If we use a landscape as an analogy, it can readily be understood that some features of the landscape will be thrown into relief and others obscured or reduced in stature depending on the angle from which the picture is taken and the focus which is used. The importance or attention which is given to individual features is their importance for that particular picture and does not necessarily reflect their importance for a picture which is taken from another angle or given a different focus.

In drawing the background against which to see the development of clinical teaching, the historical study has touched on issues which are of interest to a much wider field than nursing, for example, the processes by which an occupation 'professionalises' and the functions which education and training provide. It has also touched on issues which are of considerable interest to nursing as a whole, for example the tendency, which the emergence of both the clinical teacher and the enrolled nurse illustrate, for measures which were an immediate response to a pressing problem to become a permanent feature of the service, the way in which nursing theory is developed and the part played by nurse training/education in the development of the service as a whole. All of these issues have been to a greater or lesser extent a part of the 'landscape' against which the emergence of clinical teaching as a separate occupation within nursing has been thrown into relief.

Clearly there are many facets to these problems and a number of approaches could be used in their examination. At each stage of the study so far decisions have been

taken as to the emphasis and direction of the next stage, and these decisions have been made partly on the basis of the framework which has emerged from the data themselves and partly as a result of the researcher's judgement as to the most relevant and fruitful lines of enquiry arising from the data. Thus at an early stage it was decided not to develop an attitude survey because that seemed to be less relevant to the problems which the first exploratory study brought to light than did a study of the conceptualisation and organisation of clinical teaching. Similarly at this stage the answers to the questions "Am I still asking the most pertinent questions?" and "Which of these approaches is the most relevant in the light of what has gone before?" help to determine the next step.

The observational study showed that in spite of broad similarities between the clinical teachers there were great differences in the ways in which they used their ward based time, and particularly in the way in which they spent their time with the learners. One possible source of these differences might be the expectations which clinical teachers and others with whom they work have of clinical teaching. Indeed, this was one of the themes which emerged from the first exploratory study and which led directly to the historical study. The historical data show that this is an important aspect of the subject. Given that there seem to be two ideal models we could expect that, however they have been derived, and whether or not they were ever practical realities, they would influence other people's conceptions of 'real' clinical teaching, as well as those of the clinical teachers themselves. It is by no means certain that all of these people would interpret their ideal models in the same way even if they favoured the same model since they hold different positions in the organisation and may even belong to different social systems, i.e. the college of nursing

and the hospital. One possible way of developing the study would have been to pursue the theme of role expectations by considering the clinical teacher as an example of role conflict and role ambiguity. Since the clinical teacher herself occupies positions in both the college and the hospital, a related approach would have been to consider her as an example of a boundary position occupant and to examine clinical teaching in the light of theories of marginality and role strain.

During the early stages of the study it was this aspect that was expected to prove most profitable, but as the research progressed and particularly during the analysis of the later historical data, it became evident that the ways in which nursing and clinical teaching are conceptualised by clinical teachers and their 'significant others', and the expectations which people hold of clinical teaching are bound up with other factors which may be even more important. Three of these have already been identified in the historical study as major issues in the development of clinical teaching.

The Content of the Clinical Teacher's Teaching

The first prescription suggests a fairly circumscribed treatment of particular procedures with an emphasis on demonstration and supervision which is consonant with a task-oriented method of work. The second stresses participation in the work which has been allocated to the learner, and the use of that work as a basis for discussing the whole care of the patient. As we saw in the historical chapters, many of those who adopted this approach tended to use nursing procedures as the vehicle for their teaching, and if the wards in which they worked were using task assignment this is not surprising; nevertheless the two prescriptions suggest very different breadth and depth of material taught and of methods used.

The Career Patterns of Clinical Teachers

The two prescriptions of clinical teaching derived from the historical study also have very different implications for the career patterns of clinical teachers. If clinical teaching is thought to be a transitional post, or a training post, as the first prescription suggests, it can be expected to attract nurses in the early stages of their careers, who will be using it as a means of furthering their careers. If it is thought of as an end in itself, as the second prescription suggests, entrants can be expected to have had a more varied career pattern and they can be expected to have had some experience as ward sisters.

This study has not considered the routes by which nurses enter clinical teaching but the majority are seconded to a clinical teacher preparatory course and must normally have the support of their prospective director of nursing education. This being so, the attendance of nurses at clinical teaching courses is affected both by the concept of clinical teaching held by the individual who makes the application for secondment and by that of the educational manager who approves that application.

Conversely the pattern which an individual's career has followed and the preparatory course itself, will both affect the individual's concept of clinical teaching and the way in which she tries to implement it.

The Organisation of Clinical Teaching

It was suggested in chapter six that in order to follow the second prescription the clinical teacher would need to be familiar with the ward and the specialty as well as with the patients and their individual care. This has implications for the amount of time she would need to spend in the ward, her access to information about

patients and her knowledge and experience of the specialty, as well as for the numbers of wards and learners allocated to her. Many of these factors would be determined by the clinical teaching policy of the college rather than by the individual clinical teacher so that the way in which the clinical teaching is organised by the educational manager would have a bearing on the extent to which it would be possible to adopt the second prescription.

In short, from the historical study and from the data gathered in the field, a number of key concepts have been identified which are shown in figure 12 to be in a cause and effect relationship to each other. This is not a simple relationship, however, as the directions of the arrows show, nor, is it an equal relationship, as the different thicknesses of the arrows suggest. The relative influence of the various factors depends on such things as the personality and experience of the individuals concerned, their positions in the organisation, their control of resources and policy, and, particularly for the clinical teacher, the extent to which the preparatory course and her past experiences act as reference points. Although the clinical teaching policy of the college, the way in which it is interpreted in the circumstances, and the role expectations of the clinical teacher will be influenced by the conceptualisation of clinical teaching which the educational manager and the clinical teacher hold, it is the end result of these and other relevant factors - the way in which clinical teaching is implemented - which is important at this stage of the discussion.

The Proposition

We have now reached the second stage of theory building which is described on page 11 as one in which "relationships are established between concepts or

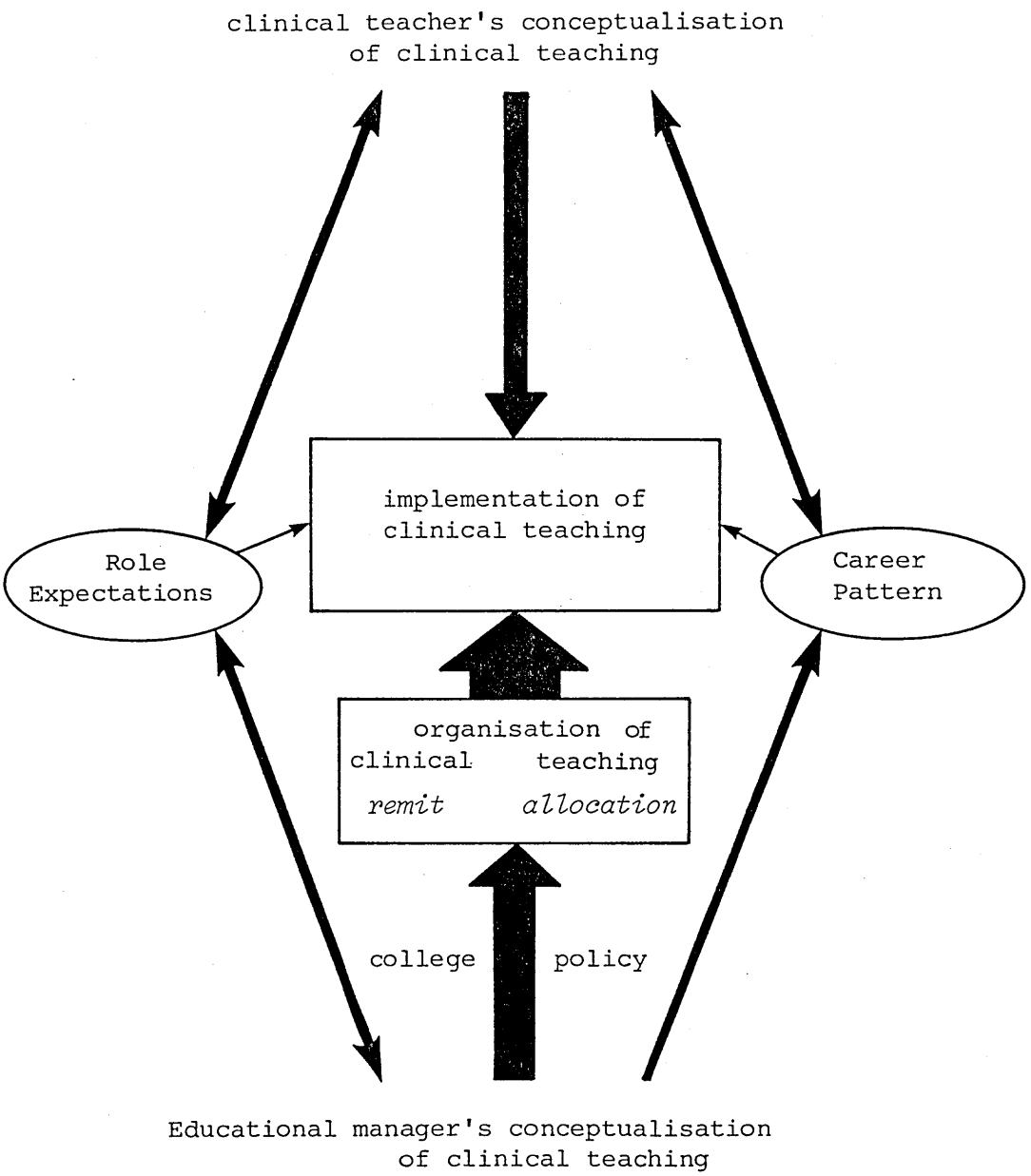


Figure 12 Relationship between concepts of clinical teaching and its implementation.

categories of concepts. These relationships then give rise to propositions which give the theory its power to explain, predict or prescribe". Figure 12 not only shows that the relationship between the implementation of clinical teaching and the other factors identified above may be one of cause and effect, it also shows that the clinical teacher's conceptualisation of clinical teaching and the way in which it is organised - its organisational context - may be in conflict. The question now arises - To what extent is the way in which the clinical teaching is implemented a reflection of the way in which the clinical teacher conceptualises clinical teaching and to what extent is it constrained by the organisational context?

This is an important question because if it can be shown that there is indeed a conflict here, then the tentative theory can be used to explain and, perhaps, predict, dissatisfaction amongst clinical teachers and might provide the basis for the revision of clinical teaching policy.

The next stage of the process is to use the tentative theory to derive hypotheses which can be tested experimentally. In order to do this the proposition expressed above must be given a more specific form. We have seen that in order to implement the second of the prescriptions derived from the historical data the clinical teacher's allocation of wards and her commitment to duties other than ward teaching need to be small enough to allow her to develop a detailed knowledge of the specialty and of the patients in the wards. We can therefore postulate two types of organisational context - one which is 'restricted', that is which conforms to the description given above, and one which does not do so and which may be termed 'broad'.

It should be noted that in describing the organisational context in this way we are dealing with comparative terms rather than absolute ones for there is no indication of how many patients or wards would need to be included to warrant the description broad. At this stage we are simply saying that the terms refer to two opposite types of allocation.

If we accept that the historically derived prescriptions reflect the ways in which clinical teaching is conceptualised we can identify four combinations of context and prescription -

	Prescription 1	Prescription 2
Restricted Context		
Broad Context		

We can then use the tentative theory to predict which of these combinations will be possible and which impossible -

	Realisation of Prescription 1	Realisation of Prescription 2
Restricted Context	Possible	Possible
Broad Context	Possible	Impossible

In reality the position is not as clear cut as the grid suggests because it takes no account of intermediate positions either in relation to the context or to the prescription which is favoured. Indeed, it must be stressed that the prescriptions themselves are generalisations derived from a variety of sources and that they are rather tentative in nature.

Given the changes in the way in which nurses have spoken and written about nursing in recent years, which is reflected in the emphasis on the concepts of total patient care and on the nursing process, it would seem to be unlikely that clinical teachers would identify strongly with prescription one. This, however, does not invalidate the grid since all four positions are logically possible. If a hypothesis derived from one of the cells can be shown to be false the whole theory will be weakened and it will be necessary to return to the original data to re-examine the categories and relationships which emerged from them.

The grid then does allow us to formulate a testable hypothesis that -

> it will not be possible to implement clinical teaching according to the second prescription if the organisational context is broad.

In order to test this hypothesis it was necessary first to identify those clinical teachers who favoured prescription two and who were working in a context which could be described as broad. It would then have to be ascertained whether or not they implemented their teaching according to prescription two, and, if they did not, an attempt had to be made to seek the reasons for this.

It was postulated above that a restricted context was one in which the clinical teacher's allocation of wards and

her commitment to other duties were small enough to allow her to develop a detailed knowledge of the specialty.

Since the total number of clinical teachers associated with basic courses in Scotland is fairly small (approximately 250 during the summer peak following the completion of the clinical teacher courses and prior to the commencement of the tutor courses) it was decided to invite all who had not participated in the exploratory work to take part in the study.

The observational study had shown that even within the same college of nursing there might be wide variations and these were summarised on page 253 using the following headings -

Remit - ward teaching
other learner contacts
administration related to ward teaching
college teaching
other college based duties

Allocation - number of wards
types of specialty
number of hospitals/distances between wards

Ward teaching - pattern
preparation/planning
content
method
record keeping

It is the first two of these major categories, Remit and Allocation, which form the framework or organisational context within which clinical teachers work and to elicit information about these a short questionnaire was designed.

Amongst the clinical teachers who had participated in the observational study were three who appeared to favour prescription two fairly strongly and two who did not. When their questionnaires were analysed it was possible to identify a number of agree/disagree statements which related to the prescriptions and which appeared to

discriminate between the two groups. These, with a number of new questions dealing with other aspects of the prescriptions, were added to the questions dealing with organisational context and the whole questionnaire was tested on the group of clinical teachers who worked with *Agnes*. Clinical teachers from two colleges had now completed questionnaires, a letter was therefore sent to the directors of the other colleges in Scotland informing them of the study, asking for permission to approach their clinical teachers and requesting the names and addresses of their clinical teachers. All of the directors gave permission for the study, some forwarded the names of all of their clinical teachers while some sent only the names of those who had agreed to participate. It was later discovered that due to annual leave, sickness or other absence a few clinical teachers were inadvertently omitted from these lists.

Altogether two hundred and four questionnaires (Appendix 6) were sent out and one hundred and seventy three were returned. This constitutes an 85% response rate and 75% of the eligible clinical teachers.

Analysis of the Questionnaires

Context

Analysis of the questions relating to context showed considerable variation over the country as a whole and within most of the colleges. However, it was possible to identify a group of fifty four clinical teachers whose remit and allocation appeared to fit the description of 'Restricted' context given on page 262. That is to say they had little or no commitment to college teaching or other college duties and their allocation was restricted to six wards or less within one hospital and dealt with

one specialty. (Six was taken as the maximum number of wards on the grounds that the only references to optimum size of allocation are in the minutes of the Central Sectional Committee of the Rcn Tutor section (1) and in a description by Geddes of his ideal of clinical teaching.(2) The first of these recommended from two to four wards with a maximum of sixty beds while the second suggests that four, or, at the most, six wards would be manageable for one clinical teacher.)

Of the remaining clinical teachers, one fairly small group appeared to be very unlike their colleagues, either because they were on night duty or worked part-time, or because they taught community nursing or obstetrics, or were in charge of a specialist post-registration course or of a pupil nurse training school. In the last case they were usually in sole charge of a school which was based in a town at some distance from the main college. The organisational context of this group as a whole has been designated 'special' in table 3 which summarises the analysis of the context.

The rest of the clinical teachers varied in their remit from having no college teaching, to spending more than half their time on this, and from having no other college commitments to claiming all of those suggested in the questionnaire. (Appendix 6) They also varied in their allocation, having between seven and seventeen wards in one or several hospitals and dealing with one or several medical specialties, and in their average number of learners from less than ten to over fifty.

In view of these wide variations it was decided to use a combination of factors to divide this group into those whose organisational context was undoubtedly 'broad' and those whose context might be considered to be part way between restricted and broad, that is 'medium'. In

the 'broad' category, therefore are those clinical teachers who had a combination of two or more of the following:

a remit which included a substantial amount of college teaching and/or a number of other college based responsibilities,

more than eight wards

wards in more than one hospital

more than one medical speciality

more than twenty learners.

This analysis is summarised in Table 3.

Category	Special	Restricted	Medium	Broad
Number	20	57	57	39

Table 3 Categories of organisational context

Conceptualisation

Given that the source of the second prescription is the writings of clinical teachers it could be expected that the majority of the clinical teachers who completed the questionnaire would claim to hold that prescription. However, in any questionnaire which tries to establish opinions or attitudes there is the possibility that respondents will give the answers which they consider to be expected of them or which they conceive of as being 'acceptable'. While the questionnaire is designed to take account of this possibility its results provide a much less certain picture of the clinical teachers' conceptualisation than it does of their context. Indeed, when the questions relating to the prescriptions were analysed it was found that although only ten appeared to favour the first prescription, there was a substantial

number who could not be clearly assigned to either group. These have been referred to as 'ambiguous' in table 4 which sets out the numbers of clinical teachers in each type of context who had a tendency to each of the prescriptions.

	Tendency to favour Prescription 1	Ambiguous	Tendency to favour Prescription 2	Total
'Special' context	0	7	13	20
Restricted context	4	14	39	57
Medium context	4	16	37	57
Broad context	2	7	30	39
Total	10	44	119	173

Table 4 Numbers of clinical teachers by prescription and context.

While the questionnaires were designed specifically to identify clinical teachers who favour prescription two and who work in a broad context they provide considerably more information about clinical teaching than this and further analysis would suggest other lines of enquiry. For the purposes of this study however, attention was confined to the designated group.

The Trial Group

The hypothesis formulated on page 264 states that it will not be possible to implement clinical teaching according to the second prescription if the organisational context is broad. It is assumed that the more strongly a person favours the prescription the more likely they will be to implement it. It is, therefore, the group of thirty clinical teachers who tend to favour the second prescription and who work in a broad context, who are of interest. Of these, three were excluded because at the time of completing the survey questionnaire they were within three months of completing a clinical teaching course. Examination of the remaining trial group of twenty seven clinical teachers had to achieve three main aims: firstly, to confirm that the clinical teachers did work in a broad context; secondly, to ascertain whether or not they implemented the second prescription; thirdly, if they did not, to explore the reasons for this.

In considering methods which might be used to achieve these aims it was essential to take account of the rapidly changing context within which the whole study was being carried out. The ways in which individuals think about clinical teaching, or any other aspect of their lives, is subject to change through time as those individuals are exposed to various experiences, including new ways of thinking in general and new ways of thinking about themselves and their lives and of particular aspects of their lives or particular topics. Throughout this study nursing education, including the educational value of the learners' clinical experience, was a regular subject of discussion in the nursing press and at conferences and study days. Potentially, all of the clinical teachers, therefore, might have modified their views of clinical teaching as

time went on. Also the pattern of nurse training in Scotland was changing. In 1978 and 1979 the then General Nursing Council published guidelines for new modular schemes of training (3,4) and these new schemes were introduced throughout Scotland during 1983. They included substantial changes in the pattern of the learners' clinical experience and these could be expected to have considerable effects on clinical teachers' patterns of work in the fairly near future. Both tutors and clinical teachers can be highly mobile groups. Although the survey showed that some remain in post for many years, the numbers who had qualified within the previous few years confirmed that many move out of clinical teaching fairly rapidly. Indeed, the high turnover rate was one of the factors which prompted this study in the first place.

For all of these reasons it was likely that the composition and characteristics of the trial group would alter significantly if there was a long interval between the survey and its follow up, or if the follow up itself was protracted. This being so it was decided to interview as many of the trial group as possible rather than attempting to draw a random sample.

The time scale of the survey had been deliberately compressed. Requests for permission to approach the clinical teachers were made in August and when the questionnaires were sent out respondents were asked to complete and return them within two weeks if possible. Thus, by November it was possible to begin to identify the trial group and to arrange interviews for December and January. Even so, at least six of the trial group had changed their remit before the interviews could be arranged. All but one of these had been "taken into the classroom" either temporarily to make good a shortage of tutors, or permanently in preparation for enrolling on a nurse tutors'

course. Consequently nine of the trial group were interviewed. Table 5 summarises the availability of the trial group for follow up interviews.

Unavailable		12
Changed post	6	
Not mutually suitable time	3	
Declined	1	
Did not answer	2	
Not asked		6
Interviewed		9
Total		27

Table 5 Availability of trial group for follow up interview

Although the interviews all had to cover similar ground, it was important to keep them as open as possible in order to explore aspects of the subject which were relevant to each clinical teacher's circumstances. The schedule therefore was based on the categories which had already been identified in earlier parts of the study and was amplified for each individual by referring to that person's answers to the survey questionnaire. Each respondent was asked to describe her work in some detail and was encouraged to talk about her approach to and feelings about the work. Only towards the end of the interview was she asked specific questions relating to the prescriptions and then only if they had not arisen spontaneously in the course of the discussion.

Within the group interviewed there were several combinations of the factors which were identified as characteristics of a broad organisational context. These are summarised as table 6.

In each of the colleges the new, modular trainings had four modules of thirteen weeks for both pupils and 'junior' students, i.e. students who were in the first stage of the two stage training. This did not necessarily mean that the learners spent thirteen weeks in one ward for in some colleges they changed wards or hospitals during the course of a module. For example, in the geriatric module learners might spend four weeks in an assessment unit and the rest of the time in a continuing care ward. None of the clinical teachers interviewed had had second stage learners in the wards but some of them did have senior students who were completing the old scheme of training.

The core of the second prescription is the provision of regular, planned teaching which will bring together the formal teaching of the tutors and other lecturers and the care which the learners are giving and seeing given in the wards. Other aspects of this prescription are the support and guidance which is given to learners by the clinical teacher; the necessity for the clinical teacher to have been an experienced ward sister; her relationship to the sisters in charge of the wards in which she works and the support and guidance which she can give to newly qualified staff nurses.

Regular planned teaching

With respect to the time which clinical teachers spend with learners on the wards there are three aspects to planning: the choice of ward, the choice of learner and the choice of patient, activity or topic which will be the subject of the teaching.

Clinical teacher	Hospitals	Medical Specialties	Number of wards	Number of learners	Classroom teaching	Other college activities
Alice	A	medicine urology trauma paediatrics	1 2 1 1	7-8 6-7 1 7	none	orientation of learners new to the hospital, guidance with care study
Gaye	B	surgery orthopaedics gynaecology ophthalmology ENT	3 1 1 1 1	20 1 4 1 1	introductory block	
Betty	C D E F	geriatrics geriatrics geriatrics geriatrics	1 3 ? ?	24	parts of introductory block	
Pamela	G H I	psychiatry psychiatry psychiatry	2 Day Hospital 8	2 1 20	2-3 days in each psychiatric module	orientation of learners new to the hospital
Helen	J K L	medicine geriatrics geriatrics	7 3	30 2	variable	entrance tests
Jean	M N	surgery geriatrics	2 2	20+ 8	parts of introductory block parts of surgical module	orientation of learners new to 'N' occasionally. Interviewing and orientation 3 months/year
Evelyn	O P	medicine geriatrics	1 2	20+ 6-8	parts of introductory block mainly	orientation of learners new to 'O'. 1-2 hours every week
Mary	Q	medicine	2	20-30	all modules & blocks for which her team is responsible	correction of written work, orientation and supervision for clinical teaching students
Morag	R	geriatrics	6	20-30	parts of introductory block, half of all geriatric modules	correction of written work

Table 6 The clinical teachers' remit and allocation.

To simplify the analysis of the interviews and to avoid repetition the clinical teachers have been divided into four groups.

a) *Pamela* and *Betty* dealt with one broad medical specialty but had learners in several wards or hospitals,

b) *Alice* and *Gaye* worked in several medical specialties within one hospital,

c) *Jean*, *Evelyn* and *Helen* worked in wards dealing with two medical specialties one of which is regarded as subsidiary by virtue of the comparatively small number of learners allocated to it,

d) *Mary* and *Morag* were allocated to a small number of wards in one specialty but had a substantial college commitment.

a) One medical specialty in several wards or hospitals

Both *Pamela* and *Betty* had a substantial college commitment to the modules dealing with their specialties, and *Betty* also contributed to the introductory block.

This meant that at regular intervals there were weeks or parts of weeks when they were not in the wards at all. *Pamela* said that this college teaching had become necessary because of the shortage of tutors with a psychiatric nursing qualification and added that

> "I feel that it's absolutely essential as long as tutors isolate themselves from the clinical areas in college."

In *Betty's* case the senior tutor said that as *Betty* and another clinical teacher were specialists in geriatric nursing it was appropriate that they should teach that specialty in the classroom as well as in the wards. Although

Betty quite liked classroom teaching she preferred clinical work and commented that

> "if you have a good run, being on the wards for a few weeks uninterrupted, it makes a tremendous difference."

Pamela was a bit vague about her pattern of work. She claimed to have a set programme, going to each pair of wards on the same day each week:

> "My programme's more or less set, in that each ward has a copy of my programme, the day that I go to the ward and so on."

However,

> "People have got amazingly short memories for clinical teachers .... they never remember it."

In view of her other commitments, for example college teaching, staff meetings, formal tutorials, it must be questioned whether she was able to be as regular in going to her wards as she claimed to be.

In spite of there being a fixed shift system with a rota for days off which meant that learners days off were determined even before they arrived in the ward *Pamela* found it very difficult to plan ahead "because there's constant changes to the duty rotas". She therefore decided on her arrival at the ward which learners she would see and what she would do with them.

Betty had no set days for going to her hospitals but she and a colleague, who was also allocated to the geriatric unit, made out a programme the previous week and circulated it to each hospital. Although this programme did not indicate which wards they intended to work in it ensured that

> "they can contact us should there be any problem and also they know we're going to be around."

This programme was determined on the basis of which learners *Betty* and her colleague wanted to see during the week:

> "According to who we've seen the week before and who we want to follow up, ensuring that we do see everybody at some point during their allocation."

The pattern of teaching of these two clinical teachers seemed to vary considerably. *Betty* and her colleague tried to have "an initial chat" with each of their learners during their first week in the geriatric units and thereafter tried to work with them for a morning either demonstrating or supervising some aspect of care which the learners had asked about or "just go(ing) in and do(ing) with her whatever work she would be doing". Where possible *Betty* discussed the care that she and the learner were giving at the time, but if "things crop up that need the time to discuss in more detail" this was done in the afternoon. Depending on the circumstances the afternoons would follow the same pattern as the morning or an informal tutorial was arranged with one or more learners. *Betty* was of the opinion that:

> "There obviously has to be some planning in advance"

but she used this as a broad framework and adapted her teaching to meet the various circumstances of the wards and the apparent needs or problems of the learners as she went along:

> "There's really no pattern to it at all."

Pamela seldom worked with the learners to give patient care and seemed to have difficulty in accepting such activities as being appropriate to psychiatric clinical teaching.

"You suggest that most of your teaching is conducted in tutorials rather than with patients present?"

"Yes. Well. It may be specific to this area, but it causes problems in..er..talking and being with patients. The time it takes to..ah..merge into the ward with the patients and so on. And because they are not always absolutely doing things in a ward situation.. ah..of a technical nature, you know. Most of my time is supporting discussion tutorial type...." (*Pamela*)

Apart from the informal tutorials with one or more learners which were held in the wards and were devoted to discussion of the learners' observation of specific patients, "the patients' previous background condition and prognosis and how the learners could communicate more effectively with the patient", once a week a formal discussion/tutorial was arranged in the nurses classroom at the main hospital for final year students following the old schemes of training. This was organised by *Pamela* and a colleague and led by one of them or sometimes by one of the charge nurses.

Both *Pamela* and *Betty* felt that a large part of their work was the provision of support and encouragement to help learners adapt to the demands of their nursing specialty.

"there is a great need for just listening to what the learner has to say. So that you could help them over problems. Even emotional problems about identification with patients and so on." (*Pamela*)

and

"Usually if they contact us it is because they are having a problem - relationships with the ward staff, or nursing care standards or something that they are concerned about .... there are very few clinical procedures that they're not going to see somewhere else .... it's much more in the way of approach and attitudes ... you're more or less helping them to come to terms with realities." (*Betty*)

b) Several medical specialties in one hospital

Three of *Gaye's* wards had been used for 'special surgical' experience for senior students who were following the old programmes of training. This meant that the numbers of students working in them was smaller than in the more general surgical wards and at the time of the interview there were no students in the ENT ward and only one in the ophthalmic and orthopaedic wards. The other specialist ward, gynaecology, was used to give junior learners general surgical experience.

Alice too had a specialist ward which was used to give learners general surgical experience, and she thought that it was inappropriate for this.

> "One of the wards can only have one learner. That's the trauma ward. It causes a problem because they are there for surgical nursing experience and it doesn't offer surgical nursing experience. I mean it's mostly head injuries and patients in for observation."

Apart from that ward to which only one learner was allocated at a time, her learners were fairly evenly spread through the wards. Only in the paediatric ward did she have senior learners and they were usually registered nurses who were undertaking further training in sick children's nursing.

Both *Gaye* and *Alice* tried to plan their work. *Gaye* tried to see each learner once every two weeks. She usually tried to see two in the morning and two in the afternoon and tended to work with the learners giving 'total patient care'. In the afternoons she sometimes held tutorials. Her visits to the ophthalmic and ENT wards were always in the afternoons and she always held tutorials there.

Alice also held tutorials in her specialist wards but was not very happy about this pattern of teaching:

"I see clinical teaching as nursing patients. That's what we're supposed to do, and it's one thing talking about it but it's entirely different doing it."

In the medical and urology wards she did work with the learners giving 'total patient care' and was usually able to arrange her work according to her plan for each individual learner.

"And you have a plan for the whole fourteen weeks?"

"Yes, I know what I'm going to do with them it's just a matter of fitting it all in" (*Alice*)

"So you're not just falling in with the allocation?"

"No, not always. I know the routine of the wards so I can plan my teaching without upsetting their routine too much, by switching the students with sister's permission, or knowing that the student will be doing X this day I can do it with her, because it will be part of the plan anyway." (*Alice*)

By contrast *Gaye* tended to base her teaching on whatever the learner had been allocated to do:

"If nurse was having Mrs. So-and-so to look after, or the patients in room 4, I will do that with her .... at the same time I have in my mind what I want to do with all the students. I have certain things that I want always to do in any area."

c) Wards dealing with two medical specialties one of which is regarded as subsidary by virtue of the smaller number of learners allocated to it

Evelyn and *Jean* both had two geriatric wards in one hospital, while *Helen* had wards in two geriatric hospitals which were 14 miles distant from each other. They all liked to go to their geriatric hospitals once a week but while *Evelyn* and *Jean* usually did do this *Helen* admitted that she did not always do so.

Evelyn and *Jean* both went to their geriatric wards on a Monday and *Evelyn* went to them on Tuesday as well "because it's simpler, just to stop confusing people." Neither of them had a formal arrangement with the ward sisters that learners would be on duty that day:

> "They might not always be on. I mean, sister knows I'm there on a Monday. She tries, but .... the staffing is not terribly good up there so I think the off duty's a headache anyway." (*Jean*)

On arrival on Monday morning *Jean* found out which learners were on duty and then decided which ward to go to and which learner to see.

> "I never really know who's going to be on. Sister and I have discussed this and she's quite happy for me to come in, look at the off duty and just attach myself to a nurse."

Thus, on these days she tended to respond to circumstances rather than to follow any predetermined teaching plan.

Helen usually phoned the hospitals on a Monday morning to find out when the greatest number of learners was on duty and if possible arranged to go to the hospitals on those days to see all the available learners.

In addition to the geriatric wards *Jean* had two surgical wards in her main hospital with an average of twenty learners. She tried to spend two days in each ward and usually decided the day before which learners she would like to see and either told the ward sister or left a note for her to that effect. She usually worked with a learner doing whatever work had been allocated to them that morning. In the afternoons she tended to discuss particular patients or disease topics with two or more learners. She tried to work with each of her learners three or four times during their thirteen weeks in the ward and to include each in at least two discussions.

Jean, therefore, plans the ward and the learner but not the topic of her teaching the day before in the main hospital, but finds this impossible in the geriatric wards where she tends to respond to circumstances and to decide who and what to teach as she goes along.

Helen did not seem to have any plan for either her geriatric wards or her medical wards except that she tried to avoid going to a ward if the sister was not on duty. She also tried to avoid going to the ward if both sisters were on duty.

She often allowed the ward staff to decide which patient she and her learner would look after:

"I would be given one or two bed patients ...."

"Sister would suggest that you take those patients?"

"Yes, I would be happy to do that."

Evelyn had a 'mixed specialty' ward in her main hospital (general medicine, neurology, cardiology) in addition to two wards in the geriatric hospital in which she worked regularly and two wards which she 'looked in on'. Her first hour or two on a Monday was usually spent 'orienting' learners new to the hospital, many of whom were not allocated to her wards. After that she tried to spend the whole day in one ward:

> "..if possible on basic nursing care, a drug round and then a teaching session in the afternoon."

In neither hospital did she attempt to plan which learner she would see.

> "I have long since stopped saying 'I wish to work with nurse so-and-so.' ... because, you know, you've got to work with them all and that's it."

Like *Helen*, *Evelyn* allowed the ward staff to decide which patients she would work with and therefore use as the focus of her teaching.

> "I tend to be given the unconscious patients or the ones which need .... a little more time spent on them .... the ward (staff) know that .... I am going to be in the ward."

d) A small number of wards in one speciality with a substantial college commitment

Mary contributed to the classroom teaching of all the modules for the intakes of learners for which her team was responsible. This meant that there might be several months at a time when she only visited her wards occasionally. Although she quite enjoyed teaching in the classroom she felt that she was being wrongly deployed:

> "I feel that I'm treated in exactly the same way as the registered tutors are and I think that this is wrong. I would like very much to reduce my classroom teaching."

This was partly because she was concerned about the lower priority which was given to teaching in the ward:

> "It seems to me that I do clinical teaching when everything else has been done, and that's not how I see clinical teaching. Teaching at ward level should be my priority .... I get very concerned that the last thing that I can do is what I'm really trained to do - teaching at ward level. I would like to have that as my main priority."

She also felt that continuity of her clinical teaching could enhance the overall standard of teaching and supervision on a ward:

> "This is why I expressed great concern to my senior tutor about the amount of time I'm away from the clinical area. .... If I can be seen to be in that ward fairly regularly then things are a bit better. When I'm not there they slide quite badly."

Mary's classroom teaching was planned well ahead so that although she was out of the wards for quite long periods she always knew in advance when this would be. During the weeks when she was able to work regularly in the wards she tended to concentrate on the junior learners who were in the first module.

> "I am concerned that since the modular system has started I have become very neglectful of the senior nurses in these wards. Just because of the system. .... I think it's very important that they (junior learners) get good supervision and support in their early modules. I think it's very important and I have concentrated on them, but I think I have done it to the detriment of the senior nurses."

She tried to see all of the junior learners twice each during the seven weeks which they spent on her wards but found that this was not always possible. (She was interviewed at the end of December)

> "It doesn't even work out as much as that sometimes. I've had situations where I've had learners come and leave the area without me even seeing them"
>
> *"Of course when you're heavily involved with a block ...*
>
> "It happens a lot. That's been the case since July of this year."

Like the other clinical teachers who were interviewed *Mary* tried to work with learners in the mornings giving patient care and often did 'tutorials' in the afternoons.

> "I try and have a morning with one learner. I try to do total patient care, and then I try to follow that up in the afternoon with a bit of theory relating to the patients whom we worked with during the morning."

This pattern of teaching necessitated keeping herself informed about the patients whose care formed the focus of her teaching and this could be difficult if she spent a lot of time in the college.

"Then I find out which of the patients I will be looking after. I then read up a bit on the nursing kardex, the nursing care plan."

"Because you may not know these patients?"

"I may not. That is why I value working in the ward for about a week at a time or several days at a time. I find that the patients get to know who I am and I get to know them." (*Mary*)

Although not working to a set pattern she did try to plan her teaching a week ahead, determining which learners she would try to see during the week according to their off duty and according to the amount of clinical teaching they had already had during that module. (The learners spent half of the module in another medical unit with a different clinical teacher.)

Morag's college teaching was restricted to the introductory blocks and the geriatric modules and had been reduced considerably since the introduction of the new schemes of training. She and one tutor were responsible for all of the geriatric modules and she gave the impression that the only difference between her remit and that of the tutor was that she also taught in five of the eight geriatric wards in the hospital. There was no clinical teacher allocated to the other three wards and the tutor did not teach in any of the wards.

Pupils, for whom the care of the elderly was the first module, spent six or seven weeks in *Morag's* hospital and the other six or seven weeks in a geriatric unit in another hospital where there was no clinical teacher. Students, for whom it was the third module, usually spent the whole thirteen weeks in the main hospital but some might go to the other unit for half of the module.

Because it was their first module *Morag* tended to concentrate on the pupils in the ward:

"Pupils I try and see at least twice. The students - it doesn't always work out that way, but I try to see them at the beginning and end of their time. Sometimes if there's a poor nurse I'll maybe work with her a bit more."

Morag felt that this was not satisfactory and she was also concerned about those learners who were allocated to the other three wards and therefore never worked with a clinical teacher at all during the module. She was in the habit of holding tutorials on a Wednesday afternoon which all of the learners in the geriatric units could attend. These were fairly formal in that they were not held in a ward and there was a 'set programme' of eight or ten topics which was then repeated. This programme had developed out of topics which learners had asked for at one time or another and was intended to supplement the lectures which were given at the beginning of the module.

"What sort of things do you do?"

"Usually building up. Something like the incontinent patient. Specially for the pupils because we give them it in class but they've never seen an incontinent patient till they go out (to the wards). We do the ageing process, diet in the elderly, communicating with the elderly."

Like the other clinical teachers, *Morag* sometimes conducted less formal 'tutorials' or discussions with one or two learners in the wards in the afternoons. She did not have a set day for going to each ward but decided on a Friday what the pattern of teaching for the next week should be. This was determined by the learners who were to be on duty and whether or not she had already worked with any of them. Usually on a Friday she was able to leave a note in each ward diary of the day on which she would work in the ward and the learners that she wanted to work with.

"Very often I don't know the patient I'm going to work with till that morning."

"Would it often happen that the day before you would say which learner you wanted to be allocated to which bay?"

"I don't often do that. I usually leave that to the ward. If I've got a very junior learner I might say I would like to do a bedbath I don't want a very ill patient."

If while she was working with a learner she identified any aspect of care in which she felt the learner needed more instruction or more practice she would arrange to work with the learner again if possible.

"If I feel she needs another session I would arrange it then. I wouldn't see her that week unless I happened to have a space. It would be the next week."

Morag usually worked with one learner in the morning and used the rest of the time to complete any outstanding college work. In the afternoons she might see several learners and felt that she was able to spend more time with them then, discussing the care which they were giving.

"I feel if you take two or three learners in the morning it disrupts the ward more .... The afternoon you can get a bit more staff on as well, you don't feel as if you're taking them away."

Working with a learner usually consisted of assisting the learners to carry out the care which the patient required, guiding them when necessary and discussing what they had done afterwards.

"I let them do it and correct them as they go along."

"So you are acting as the assistant to the learners?"

"Usually. Perhaps if it was a particular thing like catheter care I might demonstrate. If they had never done it."

In spite of saying that she dealt with 'total patient care', *Morag* gave the impression that she focussed on nursing procedures rather than specific patients. She also suggested that she was identified with the college rather than with the wards and that that made it difficult to do anything else.

> "If I had less wards, then I could be in the wards more often .... actually on site all the time. You'd be there, and they'd see you as part .. of the ward team. They see the wards and teaching as separate."

Each of these clinical teachers gave some indication of trying to plan her work. The time scale of their planning varied from the day before to the week before and three of them had set days for going to their different hospitals or wards. Only occasionally did any of them attempt to arrange beforehand which patient would provide the focus of their teaching, although, because the routine of the wards was fairly constant they usually knew the kind of nursing activities in which their learners would be engaged. Such planning as was done was almost always restricted to the choice of ward and learner.

Most of the clinical teachers had at least an outline planned for the whole of the learners' placement and this was usually related to the formal objectives for each module.

> *"You will teach that nurse in relation to whatever she has been allocated to do?"*

> "Yes. At the same time I have in my mind what I want to do with all the students." (*Gaye*)

and

> "I know what I'm going to do with them and it's a matter of fitting it all in." (*Alice*)

In each case the clinical teachers' contact with individual learners was infrequent and there were always some whom they did not manage to see at all.

Support and guidance given to the learners by the clinical teacher.

In chapter six (page 179) it was noted that clinical teachers saw themselves as doing "a very special form of teaching" which was quite different from that being done by the ward staff or the tutors. During the interviews the clinical teachers were asked to consider what they were doing for the learners which ward staff did not do, and in most cases this led to a discussion of the difference between their teaching and that of the ward staff. *Pamela*, who was the first to be interviewed said that

> "In an ideal ward there wouldn't be any need for clinical teachers. If the ward staff were sufficiently keen, motivated etc., knowledgeable about the needs of learners. If there were sufficient trained staff."

The description which she gave of her teaching, however, suggested that she spent a considerable amount of time on what she described as

> "what could loosely be described as counselling, supportive discussion. .... There's a great need for just listening to what the learner has to say, so that you can help them over problems. Even emotional problems about identification with patients and so on."

It was obvious that she felt that she was in a better position to give the learners this kind of support than the ward staff were by virtue of being outside the ward staff and therefore more objective and impartial.

The other clinical teachers, too, found themselves acting as informal counsellors to learners who had specific problems in their work or in their relationships with patients or staff, though none seemed to consider it to be as major a part of their work as did *Pamela*.

Nevertheless there was a consciousness of the need to support learners in difficult situations or while they adapted to working in a new environment. Sometimes, as in *Betty's* continuing care wards, this need took precedence over explicit teaching.

> "The learners are trying to come to terms with poor staffing, poorer facilities than they've experienced before .... There are very few clinical procedures that they're not going to see somewhere else .... it's much more in the way of approach and attitudes. .... Things being as they are I think it (counselling) has to be a priority. Otherwise we won't be training nurses for the future who have the right approach to that type of care." (*Betty*)

There was general agreement that staff nurses were more interested in teaching than were sisters, an impression that is supported by Alexander's findings (page 34), but most of the clinical teachers were rather sceptical about the teaching which the trained staff were doing.

> "I would suspect that there's not been a lot of teaching going on while I've been away. Getting shown, yes, as they go along, but .. when you're talking in terms of teaching I would put a question mark. And another question mark as to what they're teaching, because I would suspect it's not nursing. .... I think you need to educate your ward staff how to teach and what to teach." (*Alice*)

Asked what the ward staff were teaching if it was not nursing *Alice* said that they were using a 'medical model' and taught about diseases rather than about the care of the patient. An opinion which was shared by *Jean*.

> "I find the staff will .... give them a tutorial on, say, haematemesis."
>
> *"A medical topic rather than nursing?"*
>
> "Yes, and I tend not to do that."

Jean identified a number of other differences.

> "I think I'm more aware of teaching opportunities. Where something can be expanded, and giving reasons for doing things. and I'm not as scared to take longer to do something ...."

> ".... the reason I work with a learner for a whole morning is that we're trying to talk about total patient care, individualised care"

> "I think the ward staff are not really so aware of the needs of the learner. They tend to clump them all together."

> "I'm quite happy that they're doing it. - about disease processes."

Evelyn, on the other hand, thought that the ward staff knew the learners better than she did and said that in the geriatric wards

> "The ward staff's teaching is much more ..um.. patient orientated than mine is. Mine is more general. Because I'm not here long enough."

Although all of the clinical teachers initially claimed to subscribe to the view that they should be doing the teaching which the ward staff were not able or not willing to do, all except *Helen* went on to modify this by identifying ways in which their teaching differed from that of ward staff. *Helen* not only claimed that

> "To me clinical teaching is because the ward sister doesn't have time. We are really in a way still helping out. There's no doubt about it we are assisting the ward sister."

She was also the one who did least planning and who seemed most content to respond to the ward sisters' suggestions as to the pattern of her work and the learners whom she would teach.

At the opposite extreme *Gaye* and *Mary* also made little differentiation between their teaching and that of the ward sisters but that was because they had discussed their teaching with the sisters and had established a considerable measure of shared teaching in some cases.

> "We sat together and decided what we would like to teach the students .... when I go in and say I want to work with nurse, she says 'I've done such and such, would you like to do ..."
>
> *"So you actually sat down and discussed what needs to be done for these learners and which bits you would each do?"*
>
> "Oh, yes." (*Gaye*)

Gaye said that although this kind of arrangement was less structured in the other wards it was beginning to develop in the gynaecology ward. As she put it "I've always discussed bits and pieces with the sister there."

Mary too had spent time with her sisters discussing ways of sharing the teaching.

> *"So you've actually discussed sharing the teaching between you?"*
>
> "Yes, we have."
>
> *"And it works out to some extent?"*
>
> "Yes, it does. It works out very well in one ward where sister and I often say 'where have we got to?' or 'how have you got on?' One ward is very keen that all the trained staff will share the ward teaching." (*Mary*)

Alice claimed that she had tried to discuss her teaching with the ward staff but they had not shown any interest in what she was trying to do.

"The ward staff ... don't see their role as teachers. .... They don't see teaching as a priority. .... I tried it (discussing with ward staff what each might be teaching) but more or less 'do what you like.' Teaching's my baby and they allow me to get on with it as their contribution, if you see what I mean."

Her scepticism about the amount of teaching which ward staff themselves did (page 290) was shared by *Pamela* and *Morag*:

"You've got to make them aware of the learners' needs, saying to them 'would you see that nurse does this' And just guide them. But whether they do it. You can't really stand over them ...." (*Morag*)

An experienced ward sister.

All of those interviewed had held sister's posts before becoming clinical teachers, and all thought that this was necessary.

In the first place, experience of nursing was said to be important because

"in your teaching .... you refer back to your own experience." (*Helen*)

The clinical teachers did not consider that staff nurses gained sufficient experience for this:

"Staff nurses are being promoted very quickly to charge nurse grade, within a matter of six to ten months." (*Pamela*)

and

"most of the staff in the wards I have don't have a great deal of experience themselves. .... They don't come and ask things they can find in a book. They come and ask things that I've been able to answer because of my past experience. Because I've handled this kind of situation before." (*Alice*)

There was also a feeling that the experience gained as a sister was different in kind from that gained as a staff

nurse, in that it had greater breadth, more responsibility and provided a better understanding of the work of the nursing team as a whole.

> "I think as a staff nurse unless you have been quite a long time at it, you're struggling so much with your own performance, your own role. Whereas I think once you get beyond that you begin to look at the other roles." (*Betty*)

and

> "I wasn't a sister for a long time, but the experience was invaluable to me. And the responsibility .... I mean, I've been in situations where something's gone wrong and I feel I coped better with it because I've coped in the past." (*Jean*)

The clinical teachers thought that having been a ward sister helped them to establish better relationships with the ward sisters, partly because the sister knew that they could understand her problems:

> "I think you need a bit of experience" (as a sister)
>
> *"You think it's the experience of being in charge rather than the experience of nursing that's needed?"*
>
> "I think you need both. You need to know the kind of problems that can arise being in charge of a ward." (*Morag*)

and

> "when it comes to the practicalities ... for the clinical teacher to be recognised by the ward sister as one who knows her job ... as one who has been a ward sister and who knows what the running of a ward is all about." (*Mary*)

and

> "we have a teacher just now who's been a staff nurse, and she really doesn't know what it's like to be a ward sister. There are things I have to fill her in on." (*Helen*)

The clinical teachers all thought that it was the experience of being in charge of a ward which helped them to establish better relationships with their ward sisters. This was partly because the clinical teacher was not dealing with the learner and her patient in

isolation:

> "I think you need to be a ward sister before you can become a clinical teacher because you need to be sensitive to the needs of the staff as well as the patients." (*Evelyn*)

They also thought that they were on a different footing from those clinical teachers who had not been sisters:

> "It's a hierarchical structure and they (the sisters) are very status conscious." (*Alice*)

and

> "If I hadn't been a ward sister before I went to that problem ward .... she would just have got rid of me."
>
> *"You couldn't have coped with it?"*
>
> "It's the status business I think." (*Jean*)

and

> "I don't think it's just status, there's a confidence .... and this job is to do with people. It's not just about teaching techniques, it's the handling of people." (*Helen*)

Relationships with ward staff

The clinical teachers' reports show that their relationships with the ward staff and particularly with the ward sister, varied considerably. The three aspects of these relationships which the clinical teachers identified were the extent to which the ward sisters co-operated in making learners available and adapting work routines to the requirements of teaching, the standards of care maintained by the ward sister and the way she organised the work, and the extent to which the teaching was discussed with or shared by the ward sister.

All of the clinical teachers except *Pamela*, participated in the physical care of patients. Most of them worked with their chosen learner doing whatever that learner had been allocated to do and made those activities

the focus of their teaching. This pattern was not established overnight, but required that the clinical teacher "work(ed) very hard at getting to know the sisters." (*Mary*) Nor was it always easily maintained. "You've got to tread very delicately .... You've got to be very diplomatic." (*Morag*) Indeed, several of the clinical teachers indicated that there had been an initial settling in period during which they had had to allay the ward sisters' anxieties:

> "Their initial reaction would be to be very defensive but I think we're beginning to break that down now." (*Betty*)

They had also had to prove themselves to the ward staff.

> "At first they tended to look behind the screens to see what I was doing .... One of the sisters followed me around. Every time I turned I found her there. I don't find that now." (*Alice*)

and

> "It used to be said to me 'the ward's too busy, you can't have nurse'. I used to say 'this is rubbish, if the ward's too busy ... there must be something wrong. I'm quite an experienced nurse ... so maybe I can help." (*Gaye*)

For some clinical teachers and in some wards this settling in period was protracted and painful.

> "(Sister's) a very difficult person and she gave me quite a hard time for about the first year. She was very obstructive .... but it's not that bad now after four and a half years." (*Jean*)

While obstruction in *Jean's* case took the form of overt hostility, for *Gaye* it was more subtle:

> "They are always so polite and it's always so reasonable .,.. It's like having an argument with a feather pillow, there is no come back ... It's just niggle, niggle, niggle."

Even an experienced clinical teacher who was well known in the hospital could find that sometimes relationships

with ward staff were strained:

> "Most of the time there is co-operation and agreement. Sometimes not, of course. It depends on the ward circumstances." (*Pamela*)

In some cases the clinical teachers were conscious that the standard of nursing care in the ward was low and that this had a detrimental effect on teaching.

> "Although our priority is obviously to learners they're working in such an environment that their learning is affected by what's happening and there's no way you can separate the two." (*Betty*)

Sometimes this was a temporary problem caused by poor staffing and high workloads but in some cases it was a characteristic of the ward.

> "I've one ward which is a nightmare to work in ... standards that are acceptable there are not acceptable to me. I really had a very difficult year. I was welcomed with open arms. Nobody ever stopped me, nobody ever obstructive, but really some of the practices of that ward were quite horrifying." (*Mary*)

In either case the clinical teacher had to respond to the immediate circumstances as they affected her learner and her teaching, but she also had to decide what, if anything, she could or should do about the underlying problems and in this she reacted as both a nurse and a teacher.

The immediate circumstances of a very busy ward were relatively easy to deal with. The clinical teacher had a choice of withdrawing from the ward altogether or of participating in the work of the ward at the expense of overt teaching. As *Evelyn* put it:

> "I think one must learn to either go and work as a pair of hands ... or one learns to retire gracefully."

In spite of the danger of being used as 'a pair of hands' several of the clinical teachers said that at times they 'just worked' in the ward.

> "You may do it yourself or demonstrate more often when it's busy. Or you are working with them rather than making a great effort of teaching them ... you get the heaviest patient to do. The person who ... will take a lot of nursing care, a lot of time." (*Gaye*)

Their willingness to do this was seen as a means of maintaining good relationships with ward staff who were likely to feel aggrieved if learners were 'taken away' for teaching

> "I think some of them think that instead of working with a nurse you're taking a nurse away." (*Morag*)

This was particularly so when the clinical teacher wanted to give a tutorial, but it also applied to the time taken to discuss the care that they had given with the learner, even though this discussion might only take ten or fifteen minutes.

With respect to the more difficult problem of generally poor standards in a ward clinical teachers were conscious of the need to support students and influence their standards for the better

> "Sometimes it's clear cut and you can say 'this is wrong, let's get it sorted out.' Other times you're more or less helping them to come to terms with realities, without turning a blind eye to things. I don't think that would be right." (*Betty*)

At the same time they were committed to improving standards by influence and suggestion rather than by creating a direct challenge to the ward sister.

> "I have got to be very careful, all clinical teachers have, that we remember that we're not there to make decisions. In other words undermining the role and authority of the ward sister." (*Mary*)

and

"I would tend on the whole to say to staff 'what do you think about this?' and sometimes using a bit of the blarney ... I would chat to them and suggest it in a round about way." (*Betty*)

and

"If I didn't think it was right I would have a word with sister and see. Tell her my view." (*Alice*)

and

"I've made suggestions. I think that works just as well." (*Morag*)

In spite of their insistence that they could only suggest and that they did not have any direct influence on the care given to the patients but had to defer to the ward sisters decisions several of the clinical teachers said that they had taken action when they thought that patients were at risk or that standards of care were unacceptable.

"We put the patient back to bed and then had to tell sister. I found that was tricky and very traumatic." (*Helen*)

and

"I didn't do any clinical teaching I simply worked on the ward .... Then I set about doing a great deal of plain speaking to the ward sister ..." (*Mary*)

Both *Mary* and *Betty* said that they had had occasion to go to the nursing officer and senior tutor because they had been so concerned about what was happening in a ward, but such extreme action was unusual. Much more commonly the clinical teachers stressed that they took care not to undermine the authority of the ward staff and commented on their own lack of authority to make decisions which they saw as one of their main difficulties.

"One of the hardest things to accept and come to terms with is the fact that we influence so little." (*Betty*)

and

"It can be difficult to accept the lack of responsibility for patient care. The lack of decision making and continuity." (*Jean*)

and

"Somebody else makes a decision about patient care, they are taking that responsibility. I am taking

> responsibility for the standard of the care that's given, but somebody else made the decision." (*Gaye*)

Support and guidance given to staff nurses by the clinical teacher.

When they were asked if they had discussed their teaching with ward staff most of the clinical teachers took this to be a question about drawing up ward objectives for the new modules or about discussing the progress of particular learners.

> "When we discuss the students it's usually that they're doing fine. It's not that I've gone over such and such or I've taught them such and such or I would like you to do such and such ...." (*Gaye*)

In most cases they themselves did not seem to expect to talk about the content of their teaching although they did see it as a legitimate part of their work to give guidance about teaching if they were asked for it and to suggest ways in which learners who were having difficulty could be helped.

While they were willing enough to give advice about the work of the ward to staff nurses who asked for it, most of the clinical teachers did not think that this should be part of their formal remit. This was partly because it would take them away from the learners but also because it would have implications for the delegation of responsibility for patient care.

> "I did have a colleague who almost took over the running of the ward, where a very inexperienced nurse was on duty. ... I think that's where she had become too supportive." (*Mary*)

and

> "If you are there to advise newly qualified staff, you've also got to be responsible for the decision making and that brings you into being responsible for patient care." (*Gaye*)

Nevertheless, particularly when the staff nurses had themselves been the clinical teacher's students they did ask for and receive advice and teaching.

> "I've got two girls who were very recently students and who are so interested, and are so conscious of the fact that there they are, just newly qualified and sister's not there. ...
> They're discussing all sorts of things." (*Gaye*)

It can be seen from this analysis that all of the clinical teachers who were interviewed did work in the kind of organisational context which has been described as 'broad' (page 268), and that they did all seem to subscribe to a view of clinical teaching which is consistent with the second prescription (page 169). Furthermore, the descriptions which they gave of their work, and the ways in which they kept apologising for, or rationalising about what they were doing, indicate that they were unable to implement their teaching in accordance with their expressed ideal, because of the constraints imposed on them by the nature of their allocation, their other duties, and the circumstances of the ward at any time. These data all confirm the hypothesis which was formulated on page 264 that it is impossible to implement the second prescription of clinical teaching in a broad organisational context.

Although this part of the study was only designed to test that hypothesis it has yielded a great deal of information about clinical teaching which could also be used to test or to formulate other hypotheses. For example, all of the clinical teachers volunteered comments which showed that they did hold some kind of 'ideal' of clinical teaching which differed in important ways from the reality of their teaching. At the same time, they were able to express acceptance of, or even satisfaction with, the pattern of teaching which they described, even though they also apologised for it. While this dissonance was not

explored to any extent it is possible to identify from the interviews some indications of the ways in which the conflict between their ideal and their practice was resolved.

Four main strategies were indicated:

withdrawing/'opting out'
complying
acting as a change agent
trying to get the sisters involved and so moving towards the ideal

These strategies are not mutually exclusive. Some of the clinical teachers seemed to be employing more than one of them and some apparently used different ones in their various hospitals or wards.

Withdrawal

In different ways and to different extents *Pamela*, *Evelyn*, *Morag* and perhaps *Mary*, all showed evidence of distancing themselves from the conflict between the demands made by the teaching and service aspects of clinical experience. *Pamela*, who it will be remembered, seldom worked with the learners (page 277), put a lot of stress on helping them to resolve their interpersonal and emotional difficulties and in this gave the impression that she was in effect acting as a psychiatric nurse to the learners in much the same way as they were expected to be psychiatric nurses to the patients.

She may also have withdrawn into "classroom type" teaching to some extent in that she put some emphasis on the arrangements which were made for offering a formal weekly tutorial in the hospital classroom.

Morag, too, emphasised her arrangements for a formal tutorial every week and was in the process of arranging

for it to be held in the college rather than in a room near the wards. She gave the impression that she used the college as a base from which she made 'sorties' into the wards and to which she returned as soon as she had completed each episode of ward teaching.

How much of *Mary's* 'withdrawal' into classroom teaching and preparation for classroom teaching was necessitated by her remit and how much was a conscious or unconscious withdrawal from the wards is difficult to assess. She claimed to want to reduce her classroom commitments but admitted that she liked classroom teaching. She was a forceful personality with much nursing experience at ward sister and nursing officer level and might have been expected to have been able to influence the senior tutor's decisions about her remit more than she apparently had done.

Evelyn, who said that she hoped to be leaving nursing in the near future, withdrew from the conflicting aspects of her work in two ways: by focussing on the 'remedial' aspects of her contacts with learners, and by reducing her involvement in work related activities.

She stressed that she saw herself as

> "someone encouraging the people who they tell me are not going to make it. And I feel I want to say to them 'now come on nurse, the ball's between your feet .... and if you're want to make I'll go with you the whole hog."

and

> "My satisfaction is to see a child who has been given a bad report beaming at me and saying 'I made it'."

She also indicated that she had a very full life outside the hospital and that she tended to avoid taking on extra work commitments such as serving on committees, professional reading which was not clearly relevant to her immediate teaching and social contacts with work colleagues.

Compliance

Helen gave the clearest example of compliance, although *Evelyn* and *Morag* also gave some evidence of using this tactic in some of their wards. In spite of describing clinical teaching in terms which suggested a regular, planned programme of teaching about the patients whom the learners were looking after, and which involved both working with the learners to give 'total patient care' and the discussion of that care with them, *Helen* described a pattern of teaching which was random, determined by the suggestions of the ward sisters and focussed on the disease syndromes and procedures which were common to the ward.

To some extent all of the clinical teachers 'fitted in' to the ward routine and the way in which the work was organised but there were marked differences between the clinical teachers in the extent to which they seemed able or prepared to impose their own patterns of clinical teaching on the wards, but *Helen* went furthest in presenting a pattern of work which she described as 'assisting the ward sister'.

Agents of change

Reference has already been made (page 298) to the conflict experienced by the clinical teacher when standards of care or opportunities for teaching were not what they considered to be adequate, and it was noted that they all expressed a preference for attempting to change things for the better by suggestion rather than by confrontation. Both *Mary* and *Betty* described incidents in which they had challenged the prevailing standards of care of a ward and had taken the matter to higher authority. *Betty's* consciousness of her role as a change agent, however, went further than that. She spoke of her dissatisfaction

with 'the system' in some of her hospitals in terms which suggested that she saw herself both helping the learners to come to terms with 'reality' and also trying to change that reality.

> ".. we're not all that happy about the routine. We'd rather see that changed .... as I say it's hard if you want to change the way things are working."
>
> *"You suggest that you are deliberately trying to change things?"*
>
> "It's one of the hardest things. .... you're trying to put across to the learner that they've been taught the ideal and that we're working towards that. .... we have to try and be influential to what's happening in the ward."

She and a colleague had deliberately decided to work together in all of the clinical areas instead of dividing them. Although this decision had been reached partly on the grounds that it would simplify the travelling arrangements *Betty* commented that

> "I must admit that we were probably influenced as much by needing moral support from each other as anything. It can be quite lonely, going out to these areas on your own, especially if you've had a bad day. It's lovely to have someone else to gripe to ...."
>
> *"I can see tremendous advantages in the moral support."*
>
> "I know it sounds a bit silly but it is important. Certainly when C..... was away I found a tremendous difference."

This consciousness of their role as agents of change was also a feature of the tactic described as getting the sisters involved in the teaching.

Involving the sisters

The clinical teachers showed marked differences in the ways in which they liaised with the ward sisters about their

teaching, (page 291) but as already indicated (page 292) both *Gaye* and *Mary* had been able to discuss teaching as a shared activity with some of the ward sisters, and there were indications that some of the others were able to do this in a limited way with some of the staff nurses.

All of these clinical teachers were 'stayers', that is to say, they had all been in post for at least two years and although *Evelyn* and *Jean* declared their intention to leave clinical teaching, they had already been in post for thirteen and four years respectively.

The extent to which their coping strategies explained the fact that they had already been in post for longer than average is a matter for speculation. They all explicitly denied a desire to become tutors although some agreed that they would probably do so in the end because there were no career prospects in clinical teaching.

The extent to which the kinds of problems and conflicts identified here are responsible for the rapid exit from clinical teaching of so many clinical teachers is also a matter for speculation. There is ample evidence from both the fieldwork and the historical study to 'plausibly suggest' (to use Glaser and Strauss' term) a number of reasons for the dissatisfaction expressed by clinical teachers and their high turnover rates. Indeed, closer examination may well show that the state of affairs represented in figure 12 is too much of a simplification and that the constraints imposed by the clinical setting - that is the structure and immediate circumstances of the ward and hospital, over which neither the clinical teacher nor the educational manager have very much control - are sufficient to determine the way in clinical teaching will be implemented regardless of the other factors, unless, or perhaps even although, the clinical teaching is organised in such a way as to limit their effects.

Figure 13 illustrates the extra relationships and effects which may result from these external factors.

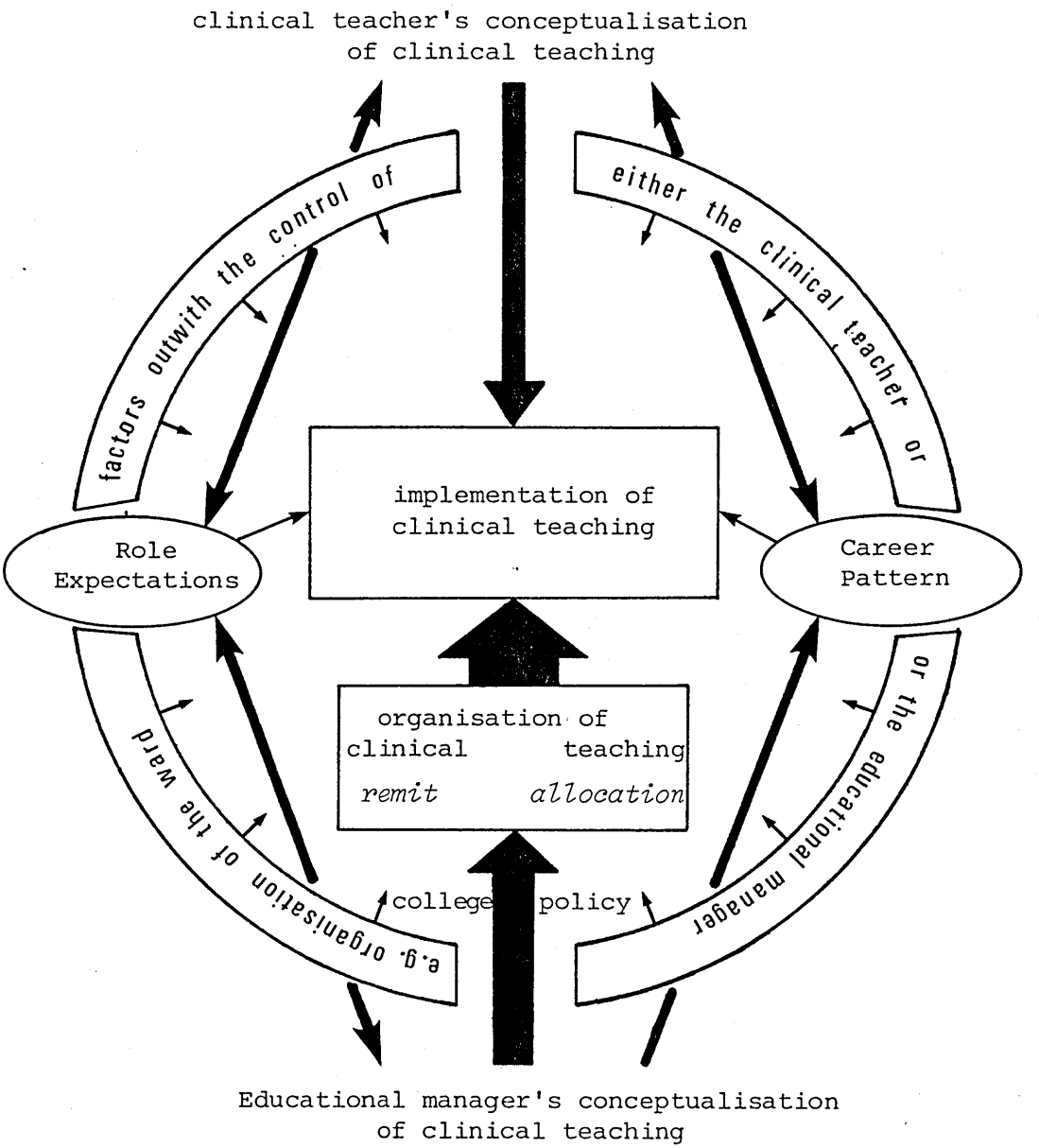


Figure 13 Relationship between concepts of clinical teaching, its implementation and external factors.

References for chapter eight

1. Rcn Tutor Section Central Sectional Committee (1962) Minutes 5th May Rcn London

2. Geddes J.D.C. (1968) Clinical Instructors : Looking Back Nursing Times 64 (18 Oct) p 1404

3. General Nursing Council for Scotland (1978) Schemes of Training for the Register of Nurses G.N.C. Edinburgh.

4. General Nursing Council for Scotland (1979) Training for the Roll of Nurses G.N.C. Edinburgh.

CHAPTER NINE

'GOING TO SEA IN A SIEVE'

This thesis has had two purposes: namely to analyse one method of generating theory and to examine the substantive area of clinical teaching. The generation of 'grounded' theory was discussed in chapter one and the kind of speculation with which the last chapter closed has brought us to the stage described there, in figure 2 (page 12), as 'theory testing'. At this stage hypotheses derived from the emerging tentative theory can be tested, and, as a result, the theory itself can be modified and refined. It is appropriate at this point, therefore, to stop and ask to what extent the method has 'worked' and what conclusions can be drawn about clinical teaching.

The Method

The point was made in chapter one that when empirical research begins at the stage of theory testing, the knowledge and concepts on which it is based are usually taken as given. If these are borrowed from another discipline there is a strong possibility that the findings of the research will advance knowledge in the parent discipline rather than in the discipline which is being studied. There is also a danger that the borrowed concepts may prove to be inappropriate with the result that wrong, or less important, questions are asked. An example of this may be given from the present study. In the early days of the study it was expected that the clinical teacher's position as a member of two rather different organisations, ward and college, would be of particular importance. It was therefore expected that sociological concepts and theories relating to role strain and marginality would provide a theoretical framework for the study of clinical teaching. As the study has progressed

these concepts have proved to be of relatively less importance. To have continued to use them would almost certainly have resulted in a study in which clinical teaching was used as a vehicle for the elucidation of sociological problems relating to role strain or marginality rather than of nursing problems relating to the organisation and implementation of clinical teaching. That is not to say that these sociological concepts may not be valuable in the study of clinical teaching, but they should be used in the context of a conceptual framework which is appropriate to the substantive area of study rather than as the main focus. In other words, especially in an emerging discipline like nursing, the concepts should be used to explain the data, the data should not be used to illustrate preconceived concepts.

One of the strengths of the grounded theory approach is that it does make possible the exploration of a substantive area of enquiry by exposing and making explicit the conceptual framework which is inherent in the data and which may be entirely different from any ready made framework which might have been more readily adopted. In the event, this study has identified contradictory, or at least inconsistent, conceptualisations at all levels of nursing and nursing education. Until these logical inconsistencies are resolved it will be impossible in any empirical study to take the conceptual framework as given. This is important, for to assume a consistent framework where none exists would not only raise the wrong questions, it might also result, in the invention of interpretations which practitioners in the field do not accept as being of particular relevance or validity. When this happens, no matter how meticulously the researcher has worked, it must be accepted that the paradigms which have been used are inappropriate and an alternative approach becomes essential.

The fact that the use of the present approach has identified this conceptual chaos and has gone some way towards providing a conceptual basis for a number of further empirical studies is evidence of its value in the study of an area which has been the subject of little previous investigation. Indeed, this process should be considered an essential prelude to any valid empirical study in areas where the conceptual framework is not already proven to be adequate, in order to clarify any conceptual muddle and to identify what exactly it is that is to be discussed.

Clinical Teaching

The employment of a nurse specifically to teach in the wards was at first a tentative local response to the perceived deficiencies in ward teaching. In each case the appointments were thought of as experimental and although some were reported in the nursing press, they developed by and large in isolation. The resulting pattern of clinical teaching was haphazard in that each hospital developed its own pattern and structure, and unbalanced, in that these appointments were made in a somewhat random fashion. Whatever consideration of the implications of these appointments there was at local level there was no general debate of a methodical kind. When clinical teaching was adopted nationally it was on a provisional basis yet there appears to have been little or no attempt to establish a trial period, to examine further what was happening, or to develop a clear policy. Although discussions did take place between government, statutory bodies and professional organisation, the new grade was not accepted wholeheartedly as a long term solution. In spite of this, money from the statutory bodies was made available to second nurses to undertake the preparatory course. This encouraged the piecemeal employment of clinical teachers to provide

immediate solutions to the problems of shortage of tutors and lack of ward teaching. In these circumstances, the controls which the General Nursing Councils began to exert were no substitute for the lack of a logical paradigm which could provide a clear framework for practice or a firm basis for change once practice was established.

In spite of the attempts to identify what was happening to students from some of the preparatory courses, and to consider clinical teachers in conjunction with all nurse teachers, which are reported in chapter two, it is difficult to escape the conclusion that clinical teaching was adopted in a tentative way as something to try, and was never formally confirmed, clarified or evaluated. With hindsight it can be argued that many of the problems which have beset clinical teaching might have been avoided if there had been a methodical evaluation of the early appointments. It might also be argued that such an evaluation could have shown whether this innovation was appropriate for any other than the general field of nursing. In the event, in the absence of any clear guidelines or restraints the 'experiment' went on growing, for, once it was established in general nursing, it was difficult to prevent its adoption in any other area in which the level of ward teaching was thought to be inadequate. As in general nursing, once having created a group who were doing this kind of work it was a short step to allowing them to undertake the preparatory course, with the result that the formulation of a considered policy was pre-empted.

In midwifery, for example, clinical teachers were first employed in Scotland to teach general nursing students who were seconded for obstetric experience in wider basic training programmes. Where there was a shortage of tutors or where these new programmes resulted in a greatly increased number of learners in the wards,

it was understandable that this new teacher should be used to make good some of that deficiency by taking into her orbit all of the students working in the wards, and, in any case, it is difficult for a teacher working with students in a ward to teach one kind of student and to ignore the others.

This study has provided an attempt to tease out the conceptualisations and logical framework which may have existed at the time and to provide a methodical examination of the basis and implications of the creation of a separate grade of clinical teacher. To do this retrospectively, however, has its weaknesses for some of the evidence which is required is no longer available and, in any case, the argument is inevitably coloured by present conditions and concerns and ways of thinking rather than by those which pertained at the time. Nevertheless, the study has endeavoured to identify a clearly recognisable framework which can act as a pattern for the future.

The Way Ahead

Nursing research has developed quite rapidly in this country over the last two decades and there is now a steadily growing volume of published work. There are, however two major problems which raise essential questions in a practice discipline.

The first is the apparent distance between nursing research and nursing practice. As yet there is little evidence that practitioners either make use of research findings in their practice or that they think of research as a tool for guiding practice or for solving practice problems. This problem has already been touched on above (page 310) where it was suggested that in a practice discipline it is essential that the assumptions and

concepts on which research is based are recognised by practitioners to be relevant and valid. Only when this is the case will it be possible to complete the third stage of theory building identified in chapter one (page 11), *i.e.* the modification and refinement of practice.

The second problem arises from the fragmentation of nursing research. Extant studies seem unrelated and there are few identifiable foci. Decisions about which areas are subjected to investigation and which particular questions are to be asked seem to be largely a matter of individual choice and opportunity. This militates against the development of a coherent theoretical basis for nursing, leads to repetition and does not encourage researchers to build on earlier research to any great extent. Until at least the outline of a reasonably consistent theoretical framework in nursing which is shared by both the researchers and the practitioners emerges, the results of research are likely to continue to be largely unused and unimplemented.

As this study has progressed, it has identified something of the kaleidoscopic nature of nursing and of clinical teaching. It has also identified a number of questions and topics which might warrant further study for example, the nature of the coping strategies which clinical teachers adopt to resolve their role strain, the relationship between the amount of time which a clinical teacher spends in planning and in 'social' contacts with ward staff, and the nature and quality of the teaching which she does. By identifying the lack of conceptual consistency, it has also laid the foundation for developing, or at least clarifying, some of the concepts so that some of these themes can be taken up and explored in a reasonably coherent context.

Reference has already been made to changes which have taken place in the statutary framework for nursing education since this study was begun. The National Board for Nursing, Midwifery and Health Visiting for Scotland has set up a working group to consider the preparation of nurse teachers, and it is widely expected to recommend changes. The Education Policy Advisory Committee of the UKCC has, as one of its priorities, an examination of the function and preparation of teachers in all sections of the profession. The Royal College of Nursing has also set up a working group to consider nursing education and to make recommendations. The concurrence of these activities is not coincidental. Apart from the progressive unease about the position of the clinical teacher in nursing, there is the consideration that there are similar 'practice' teachers in midwifery, district nursing and health visiting. Until now these have usually been prepared in different ways by courses of different lengths. Like the clinical teachers they often go on to take tutors' courses which are also specific to district nursing, health visiting and midwifery. There is little doubt that much overlap and repetition could be avoided if a more rational system of teacher preparation could be devised. However, if the mistakes of the past are to be avoided in the future, not only in relation to the preparation and function of nurse teachers but in any reassessment of nursing education generally, the foundations must be examined to see if they are sound. Any other course would be like setting out on a voyage of discovery in a leaky boat without navigational aids. Although the Jumblies did eventually return, we might find ourselves turning round and round for much longer than twenty years, or, worse still, shipwrecked altogether.*

*With apologies to Edward Lear and his "They Went to Sea in a Sieve"

JOB DESCRIPTION 4

THE CLINICAL TEACHER

The Clinical Teacher is a member of the tutorial staff and responsible to the Director of Nurse Education but she spends most of her time teaching learners in the wards and departments of the hospital.

The plan of the clinical teacher's work varies considerably in differing units but most clinical teachers help to teach students in the ward team, as well as those from the introductory block and subsequent study blocks (modules).

They tend to give more time to inexperienced students who usually need more supervision and support than their senior colleagues - though the needs of the senior learners must also be catered for.

This is sound practice because it is important that all students/ pupils realise that they need to continue to learn throughout their period of training, indeed, many senior learners need a great deal of help when tackling situations for which their previous experience has not prepared them. However, when the number of learners is large and there are only one or two clinical teachers it may be considered advisable to limit their teaching to the less experienced students so that all have the opportunity of benefitting from some clinical instruction.

A clinical teacher may be responsible for a group of about twenty students for the first few months of their training, teaching them wherever they are gaining experience. However, a more common arrangement is for her to be attached to a group of wards, teaching the learners who are gaining experience in this area. This arrangement has advantages because the clinical teacher can more easily establish good working relationships with the charge nurses, staff nurses and medical staff. Furthermore, she has a better opportunity of knowing the patients, which is essential if clinical teaching is to be concerned with total patient care rather than only helping students to perfect techniques.

The day to day planning of clinical instruction is undertaken jointly with the charge nurse and the clinical teacher. When the clinical teacher is attached to a group of wards there is usually an overall plan drawn up with the assistance of all the ward sisters and the nursing officer of the unit. Thus the clinical teacher may work for a week in each ward for a day or half-day in each - the possible variations are many. The important points to bear in mind are:-

1. The plan suits all concerned
2. The clinical teacher is available in each ward when there are the maximum number of opportunities for teaching.
3. The plan is sufficiently flexible to allow for adjustments if necessary.

There are opportunities for clinical teaching throughout twenty-four hours but usually the most fruitful times for teaching are during the reasonably busy periods of the day. However, many clinical teachers find it useful to work during the late evening or early morning when inexperienced learners may lack supervision and guidance whilst some accompany learners for a night or two of the first night duty.

If the clinical teacher is to make a useful contribution she must work in close liaison with both the tutors and the charge nurses. She keeps in contact with the school by taking an active part in meetings of the tutorial staff and by consulting frequently with the tutors about the learners programmes. She attends lectures, demonstrations, case conferences and ward rounds so that she is better able to help the learners relate theory to practice.

The clinical teacher has frequent contact with the charge nurses on whom she is largely dependent for the success of her work. She needs their active co-operation; tolerant acquiescence to her visits is not enough - a charge nurse who has taken steps to foster an environment conducive to learning good nursing practice, and who herself takes every opportunity to teach, is the ideal partner for a clinical teacher.

It is essential that a harmonious working relationship is established between them for if discord is apparent the learner's progress will be inhibited. (Because of divided loyalties)

The clinical teacher is solely concerned with clinical teaching - she has no responsibility for ward administration and is not a member of the ward team. Therefore, she does not interfere with the organisation of the work, and is guided by the charge nurse in matters concerning the patients treatment. She does not deal with visitors' problems.

The clinical teacher cannot be regarded as an extra member of ward staff, the work she does is only incidental to her primary task of teaching. Naturally, she may assist a learner when the ward is busy <u>but</u> the student must need the clinical teachers guidance with the task she is performing.

Finally, the charge nurse can assist the clinical teacher's function by drawing her attention to the learner's needs so that teaching can be geared to meet these and by informing her of any teaching opportunities which arise when the clinical teacher is not in the ward.

JOB DESCRIPTION 5

PRIMARY ROLE: Clinical Teacher to Student & Pupil Nurses in General Nursing

ACCOUNTABLE TO: Senior Nurse Tutor (Team Leader)

MINIMUM QUALIFICATIONS: SRN RCNT

FUNCTIONS

A. PROFESSIONAL

1. Creating and participating in learning situations in Clinical Nursing Areas and in the Nurse Education Centre. Teaching learners in conjunction with Ward and Departmental staff in accordance with agreed nursing and education policies and objectives.

2. Interpreting learning needs in the Clinical Nursing areas and communicating these to the relevant education and nursing service staff.

3. Assisting in the preparation and organisation of examinations and assessments in practical nursing.

4. Acting as an examiner/assessor in practical nursing.

5. Attending meetings as a representative of the nurse education division.

6. Keeping abreast of developments in nursing and nursing education.

7. Publicising nursing as a career and participating in promotional activities.

8. Participation in selection interviews for nurse learners.

B. ADMINISTRATIVE

9. Liaising with Charge Nurses to arrange clinical teaching for learners allocated to the Unit.

10. Keeping records of clinical learning situations experienced by learners.

11. Reporting to Senior Nursing Officer (Education) on:-

    (a) results of clinical teaching programme
    (b) progress and needs of learners in clinical areas
    (c) needs and problems bearing on nurse education raised by staff in the units.

12. Assisting the Senior Nurse Tutor in the provision of information concerning trends in clinical work.

13. Participating in "In-Service" Education.

C. PERSONNEL

14. Counselling of learners.

15. Report on learners progress to staff of the teaching team.

This Job Description is intended as a guide and will require amendment in response to developments in nurse education in this School of Nursing.

JOB DESCRIPTION 6

RESPONSIBLE TO: Director of Nurse Education

SUMMARY OF DUTIES:

Responsible for the clinical teaching of Student and Pupil Nurses (as agreed with Director of Nurse Education) in specific units of the Area School of Nursing. To conduct tutorials/seminars in the School of Nursing as required.

(a) DUTIES AND RESPONSIBILITIES OF THE POST

1. Preparation of a programme of clinical teaching in the medical or surgical areas at ..... Hospital and ..... Hospital.

2. Teaching students and pupils in the ward situation by example, discussion and ward rounds.

3. Observing that all agreed standard procedures are being followed.

4. Ensuring that all learners are seen if possible every two weeks.

5. Maintaining good relationships and personal contact with nursing and medical staff.

6. Reporting on progress of Student and Pupil Nurses to the Director of Nurse Education

7. Maintaining records of clinical teaching of each student and pupil.

8. Arranging visits to wards for students and pupils in study blocks to study specific diseases and observe relevant procedures.

9. Conduct seminars on wards.

10. Inform pupils and students of any patient with condition relevant to their studies and arrange access to patient with Ward Sister at convenient time.

11. The arrangement and carrying out of ward conferences hopefully on a weekly basis with accent on behavioural care, using modern audio-visual aids.

(b) ASSESSMENTS

1. The Clinical Teacher will be expected to fully participate in the active arrangements and assessing of Student and Pupil Nurses throughout the Area School of Nursing.

(c) GENERAL

1. Attending monthly meetings in specific area with Nursing Officer and Ward Sisters.

2. Attending procedure meetings and submitting ideas for improvement of procedures.

3. Available for counselling and correcting written monthly assignments for a set group of students.

4. Assisting generally with recruitment and escorting parties of school children around the hospitals.

Letters, questionnaires and interview schedules used in the observational study

(a) Letter to Divisional Nursing Officer

(b) Letter to Director of Nurse Education

(c) Learners' questionnaire

(d) Trained staff questionnaire

(e) Tutors' questionnaire

(f) Clinical teachers' questionnaire

(g) Clinical teacher interview schedule

(h) Director of Nurse Education interview schedule

(a) Letter to Divisional Nursing Officer

Dear

RESEARCH PROJECT: CLINICAL TEACHING

As you know, some time ago I approached (C.A.N.O.) with a view to carrying out some of my research in your District and I am now discussing with (D.N.E.) arrangements for inviting her clinical teachers to take part in the study. The research is directed towards clinical teachers themselves and requires that I spend some days observing them at work. During this observation time I should like to invite trained staff to complete a short questionnaire.

I am writing to you now to ask permission to do this and to ensure that you are fully informed of the project. Experience so far suggests that my presence with the clinical teacher does not interfere with the work of the wards at all and every effort is made not to intrude on patients' privacy.

Until I know which clinical teachers are willing to take part in the study I am unable to indicate which hospitals would be involved but would be obliged if you would let me know whether it is in order to proceed and whom I should contact to make more detailed arrangements. Meanwhile if you or your staff would like any further information I will be glad to supply it and to discuss the project with you.

With many thanks.

Yours sincerely,

Miss C.M. Robertson
Course Leader

(b) Letter to Director of Nurse Education

Dear

Research Project: The Development and Practice of Clinical Teaching

Further to my correspondence with (C.A.N.O.) I am now beginning to plan the next phase of this research project and wonder if it would be possible to do this in the College?

The participation that I am seeking is of three kinds -

(a) the completion of a questionnaire by tutors and by the trained staff and learners with whom each participating clinical teacher works;

(b) a period of observation of each clinical teacher, covering a full working week but probably spread over 2-3 weeks;

(c) a semi-structured interview lasting approximately 45 minutes with yourself, the senior tutors concerned and each of the clinical teachers.

Experience in other places suggests that the questionnaires can be completed in 10-15 minutes and, that after an initial introductory period, my accompanying clinical teachers day by day does not interfere with the work of the wards. Every effort is made not to intrude on patients' privacy during intimate procedures.

If you are agreeable to these proposals perhaps I could come and discuss arrangements with you? Meanwhile if you would like any further information I will be pleased to supply it.

With many thanks.

Yours sincerely,

Miss C.M. Robertson
Lecturer

(c) Learners' questionnaire

CLINICAL TEACHING STUDY

Learner No _____

This questionnaire is about your experience of clinical teaching. Please complete the questions about your course and your contacts with clinical teachers by circling the number of the appropriate answer or by writing your answer in the space provided.

Then read the statements 9 - 71 carefully and indicate whether, from your experience of clinical teachers, you would agree or disagree with it.

Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase which most closely expresses your opinion, i.e. 5 for 'strongly agree'; 4 for 'agree'; 3 for 'not sure'; 2 for 'disagree'; or 1 for 'strongly disagree'.

When you have completed it, the questionnaire, which will be treated confidentially, should be returned to me in the envelope provided.

Thank you for your help.

C.M. Robertson

Hospital _____ Ward No _____

A. What kind of things do you expect the clinical teacher to do with you?

B. What does the clinical teacher do for you that other staff do not do?

C. Can you suggest any things which clinical teachers do which you think they should not do?

D. Can you suggest any things which clinical teachers do not do which you would like them to do?

Please circle the appropriate number.

1. What kind of course are you undertaking?

Enrolment	1
Sick Childrens or General Registration	2
Mental Deficiency or Mental Registration	3
Other	4

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2. Which year of training have you reached? 1 2 3

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3. How many clinical teachers have worked with you in this course so far?

one - 1
two - 2
three - 3
four - 4
more than four - 5
none - 6

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4. In your present ward, how often do you have contact with a clinical teacher?

daily - 1
several times a week - 2
once a week - 3
less often - 4
none - 5

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5. On average, how long does the clinical teacher spend with you?

15-30 mins - 1
30-45 mins - 2
45-60 mins - 3
over 1 hour - 4

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6. When a clinical teacher spends time with you how often is it because you asked for help?

Never - 1
Seldom - 2
Often - 3
Always - 4

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7. How helpful do you find your contacts with the clinical teacher?

Very helpful - 1
helpful - 2
Not Very helpful - 3
Very little help - 4
No help at all - 5

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8. Would you like to have a clinical teacher carry out your allocated work with you for a whole morning or afternoon.

Yes - 1
No - 2

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

9.	Clinical teachers really belong more the college than to the wards.	5	4	3	2	1
10.	The clinical teacher should let sister know what he/she wants to do and with which learner he/she wants to work beforehand.	5	4	3	2	1
11.	The clinical teacher does let sister know what he/she wants to do and with which learner he/she wants to work beforehand.	5	4	3	2	1
12.	The clinical teacher should plan his/her teaching ahead so that ward staff can make the necessary arrangements.	5	4	3	2	1
13.	The clinical teacher does plan his/her teaching ahead so that ward staff can make the necessary arrangements.	5	4	3	2	1
14.	Clinical teachers should be guided by tutors about which learners to teach most in the wards.	5	4	3	2	1
15.	The sister and the clinical teacher do plan the ward teaching together.	5	4	3	2	1
16.	It is unrealistic to expect clinical teachers to spend most of their time giving patient care with learners.	5	4	3	2	1
17.	Sister does tell the clinical teacher which learners need help so that he/she can work with them.	5	4	3	2	1
18.	Sister allocates the ward work and the clinical teacher just fits in.	5	4	3	2	1
19.	Clinical teachers have a wider, more lasting influence on the learner than tutors have.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree; 4 Agree; 3 Not Sure; 2 Disagree; 1 Strongly Disagree

20.	The trained staff and the clinical teacher discuss the learners' progress together.	5	4	3	2	1
21.	Most clinical teachers go out of their way to help students.	5	4	3	2	1
22.	The clinical teacher is much better at teaching nursing than the ward staff.	5	4	3	2	1
23.	The clinical teacher never seems to be there when I need her.	5	4	3	2	1
24.	I would like more opportunity to work with a clinical teacher.	5	4	3	2	1
25.	Clinical Teachers do not seem to be very well thought of by tutors.	5	4	3	2	1
26.	I would rather go to ward staff for help than to the clinical teacher	5	4	3	2	1
27.	The clinical teacher is not really sure of the ward routine.	5	4	3	2	1
28.	The clinical teacher goes over procedures but does not tell me what I really want to know.	5	4	3	2	1
29.	The clinical teacher is not as competent a nurse as the ward staff.	5	4	3	2	1
30.	Clinical teachers do not seem to be very well thought of by ward staff.	5	4	3	2	1
31.	The clinical teachers' theoretical knowledge is not as great as that of the tutors.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

32.	Clinical teachers are not very experienced nurses.	5	4	3	2	1
33.	The clinical teachers seem to have close contacts with some of the trained staff.	5	4	3	2	1
34.	The trained staff don't teach much if there is a clinical teacher attached to the ward.	5	4	3	2	1
35.	Tutors have a more essential part in the teaching of nurses than clinical teachers have.	5	4	3	2	1
36.	I would like to know beforehand when the clinical teacher is coming to work with me.	5	4	3	2	1
37.	It is good to have a clinical teacher in the ward when we are very busy.	5	4	3	2	1
38.	Ward staff do not seem to know much about what clinical teachers do.	5	4	3	2	1
39.	Tutors seem to be more senior than clinical teachers.	5	4	3	2	1
40.	It is not possible for the clinical teacher to arrange what he/she will do with me beforehand.	5	4	3	2	1
41.	To do the job properly the clinical teacher needs to have been a ward sister/charge nurse.	5	4	3	2	1
42.	Clinical teaching is just a preparation for becoming a tutor.	5	4	3	2	1
43.	Clinical teachers tend to interrupt the ward work too much.	5	4	3	2	1
44.	Clinical teachers do not seem to have much contact with the patients.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

45.	Having clinical teachers in the wards raises the standard of nursing care.	5	4	3	2	1
46.	Clinical teachers have a wider, more lasting influence on learners than do ward staff.	5	4	3	2	1
47.	Clinical teachers should not as a rule be taking learners away from the bedside to give them tutorials.	5	4	3	2	1
48.	Clinical teachers need to be very experienced nurses.	5	4	3	2	1
49.	Clinical teachers are not in the wards often enough to have any real impact on ward teaching.	5	4	3	2	1
50.	Having clinical teachers in the wards raises the standard of ward teaching.	5	4	3	2	1
51.	The clinical teacher tells the trained staff what he/she has been doing with the learners.	5	4	3	2	1
52.	Trained staff don't need to teach so much if there is a clinical teacher attached to the ward.	5	4	3	2	1
53.	When the clinical teacher comes to the ward, trained staff always make a point of telling him/her what is going on.	5	4	3	2	1
54.	The trained staff tell the clinical teacher what they have been teaching/showing the learners.	5	4	3	2	1
55.	Clinical teachers really belong to the wards rather than the college of nursing.	5	4	3	2	1
56.	The ward sister and the clinical teacher should arrange to share the ward teaching between them.	5	4	3	2	1
57.	The sister should tell the clinical teacher which learners need help so that he/she can work with them.	5	4	3	2	1
58.	Sister allocates the work and the clinical teacher should just fit in.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

59.	Clinical teachers seem to spend a lot of time at the college of nursing.	5	4	3	2	1
60.	The clinical teacher does not seem to know what the trained staff have been showing me.	5	4	3	2	1
61.	Clinical teachers do not seem to have much contact with medical staff.	5	4	3	2	1
62.	Clinical teachers seem to know some of the tutors very well.	5	4	3	2	1
63.	I find it unsettling when a clinical teacher comes to work with or without warning.	5	4	3	2	1
64.	The trained staff and the clinical teacher share the ward teaching between them.	5	4	3	2	1
65.	The clinical teacher and the ward sister should plan the ward teaching together.	5	4	3	2	1
66.	Clinical teachers tend to interfere with the organisation of the ward.	5	4	3	2	1
67.	Ward staff are more essential to the teaching of nurses than clinical teachers are.	5	4	3	2	1
68.	I would rather seek information and help from tutors than from the clinical teacher.	5	4	3	2	1
69.	I find it hard to think of the clinical teacher as being a real nurse.	5	4	3	2	1
70.	The trained staff and the clinical teacher should discuss the learner's progress together.	5	4	3	2	1
71.	It is unrealistic to expect clinical teachers to plan their teaching with trained staff.	5	4	3	2	1

(d) Trained staff questionnaire

CLINICAL TEACHING STUDY

Trained Staff No _____

This questionnaire is about your experience of clinical teaching.

Please answer questions 1 - 3 in the space provided. When you have done that, please read statements 4 - 55 and indicate whether, from your experience of clinical teachers, you would agree or disagree with it.

Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase most closely expressing your opinion, i.e. 5 for 'strongly agree', 4 for 'agree', 3 for 'not sure', 2 for 'disagree' or 1 for 'strongly disagree'.

When you have completed it, the questionnaire, which will be treated confidentially, should be returned to me in the envelope provided.

Thank you for your help.

C.M. Robertson

Hospital_____ Ward No_____

1. Can you suggest any things which the clinical teacher does which you think he/she should not do?

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2. Can you suggest any things which the clinical teacher does not do which you would like him/her to do?

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3. Please indicate those aspects of the clinical teacher's job which you think are most helpful.

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

4.	Would you please circle the number opposite your grade.	Enrolled Nurse 1 Staff Nurse 2 Sister/Charge Nurse 3				
5.	Trained staff don't teach so much if there is a clinical teacher attached to the ward.	5	4	3	2	1
6.	Having a clinical teacher in the ward raises the standard of nursing care.	5	4	3	2	1
7.	Clinical teachers are not on the whole very competent nurses.	5	4	3	2	1
8.	Ward staff are more essential to the teaching of nurses than clinical teachers.	5	4	3	2	1
9.	I would like the clinical teacher to come to the ward more often.	5	4	3	2	1
10.	Clinical teachers have a wider, more lasting influence on learners than do ward staff.	5	4	3	2	1
11.	Clinical teachers have a real contribution to make to ward teaching.	5	4	3	2	1
12.	Clinical teachers tend to interrupt ward work too much.	5	4	3	2	1
13.	Clinical teachers are not in the ward often enough to have any real impact on ward teaching.	5	4	3	2	1
14.	It is good to have a clinical teacher with a learner when we are very busy.	5	4	3	2	1
15.	The clinical teachers have a wider, more lasting influence on the learner than the tutors have.	5	4	3	2	1
16.	Clinical teachers are likely to be of more practical help to learners than are tutors.	5	4	3	2	1
17.	Clinical teaching is just a preparation for becoming a tutor.	5	4	3	2	1

lease circle the appropriate number for each statement according o the following code:

Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

8.	The trained staff and the clinical teacher discuss the learners' progress together.	5	4	3	2	1
9.	I would like to know more about what the clinical teacher is teaching in my ward.	5	4	3	2	1
0.	The trained staff and the clinical teacher should arrange to share the teaching between them.	5	4	3	2	1
1.	The clinical teacher should let sister know what he/she wants to do and with which learner he/she wants to work beforehand.	5	4	3	2	1
2.	The clinical teacher does let sister know what he/she wants to do and with which learner he/she wants to work beforehand.	5	4	3	2	1
3.	The clinical teacher should plan his/her teaching ahead so that ward staff can make the necessary arrangements.	5	4	3	2	1
4.	The clinical teacher does plan his/her teaching ahead so that ward staff can make the necessary arrangements.	5	4	3	2	1
5.	The sister and the clinical teacher should plan the ward teaching together.	5	4	3	2	1
6.	The sister and the clinical teacher do plan the ward teaching together.	5	4	3	2	1
7.	It is unrealistic to expect clinical teachers to spend most of their time giving patient care with learners.	5	4	3	2	1
8.	The trained staff and the clinical teacher do arrange to share the teaching between them.	5	4	3	2	1
9.	Sister should tell the clinical teacher which learners need help so that he/she can work with them.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

30.	Tutors have a more essential part in the teaching of nurses than clinical teachers have.	5	4	3	2	1
31.	The clinical teachers' theoretical knowledge is not as great as that of the tutors.	5	4	3	2	1
32.	Clinical Teachers do not seem to be very well thought of by tutors.	5	4	3	2	1
33.	Clinical teachers spend a lot of their time in the college of nursing.	5	4	3	2	1
34.	Clinical teachers really belong more the college than to the wards.	5	4	3	2	1
35.	I do not know much about what the clinical teachers do.	5	4	3	2	1
36.	It is not possible to arrange beforehand what a clinical teacher will do in the ward.	5	4	3	2	1
37.	Clinical teachers need to be very experienced nurses.	5	4	3	2	1
38.	To do the job properly clinical teachers need to have been ward sisters/charge nurses.	5	4	3	2	1
39.	The clinical teacher tells the trained staff what he/she has been doing with the learners.	5	4	3	2	1
40.	Trained staff don't need to teach so much if there is a clinical teacher attached to the ward.	5	4	3	2	1
41.	When the clinical teacher comes to the ward, trained staff always make a point of telling him/her what is going on.	5	4	3	2	1
42.	The trained staff tell the clinical teacher what they have been teaching/showing the learners.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

43.	Sister does tell the clinical teacher which learners need help so that he/she can work with them.	5	4	3	2	1
44.	Sister allocates the ward work and the clinical teacher just fits in.	5	4	3	2	1
45.	Clinical teachers tend to interfere with the organisation of the ward.	5	4	3	2	1
46.	Clinical teachers should not, as a rule, be taking learners away from the bedside to give them tutorials.	5	4	3	2	1
47.	It is not realistic to expect the clinical teachers to plan their ward teaching with the ward sisters.	5	4	3	2	1
48.	Having clinical teachers in the wards raises the standard of ward teaching.	5	4	3	2	1
49.	Clinical teachers should be guided by tutors about which learners to teach most in the wards.	5	4	3	2	1
50.	Clinical teachers really belong to the wards rather than the college of nursing.	5	4	3	2	1
51.	The trained staff and the clinical teacher should discuss the learner's progress together.	5	4	3	2	1
52.	Sister allocates the work and the clinical teacher should just fit in.	5	4	3	2	1
53.	Clinical teachers do not seem to have much contact with patients.	5	4	3	2	1
54.	Clinical teachers do not seem to have much contact with medical staff.	5	4	3	2	1
55.	Clinical teachers are not very experienced nurses.	5	4	3	2	1

(e) Tutors' questionnaire

CLINICAL TEACHING STUDY

Tutor No T

Please read each of the statements overleaf and indicate whether, from your experience of clinical teachers, you would agree or disagree with it. Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase which most closely expresses your opinion, i.e. 5 for 'strongly agree', 4 for 'agree', 3 for 'not sure', 2 for 'disagree' or 1 for 'strongly disagree'.

Then please answer questions A and B in the space provided. The completed questionnaire, which will be treated confidentially, should be returned to me in the envelope provided.

Thank you for your help.

C.M. Robertson

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

1.	The clinical teachers seem to have close contacts with some of the trained staff.	5	4	3	2	1
2.	Clinical teachers have a wider, more lasting influence on learners than do ward staff.	5	4	3	2	1
3.	Ward staff are more essential to the teaching of nurses than clinical teachers are.	5	4	3	2	1
4.	Clinical teachers have a real contribution to make to ward teaching.	5	4	3	2	1
5.	Clinical teachers are not in the wards often enough to have any real impact.	5	4	3	2	1
6.	Having clinical teachers in the wards raises the standard of ward teaching.	5	4	3	2	1
7.	Clinical teachers should confine themselves to ward teaching.	5	4	3	2	1
8.	Clinical teachers should assist in the whole work of the school.	5	4	3	2	1
9.	Clinical teaching is just a preparation for becoming a tutor.	5	4	3	2	1
10.	The same person cannot combine classroom teaching and clinical teaching adequately.	5	4	3	2	1
11.	Ward teaching is more difficult than classroom teaching.	5	4	3	2	1
12.	The ward sister and the clinical teacher should arrange to share the ward teaching between them.	5	4	3	2	1
13.	The sister should tell the clinical teacher which learners need help so that he/she can work with them.	5	4	3	2	1
14.	Sister allocates the work and the clinical teacher should just fit in.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

15.	Clinical teachers should not as a rule be taking learners away from the bedside to give them tutorials.	5	4	3	2	1
16.	Clinical teachers need to be very experienced nurses.	5	4	3	2	1
17.	To do the job properly clinical teachers need to have been ward sisters/charge nurses.	5	4	3	2	1
18.	It is unrealistic to expect clinical teachers to spend most of their time giving patient care with learners.	5	4	3	2	1
19.	Clinical teachers should be guided by tutors about which learners to teach most in the wards.	5	4	3	2	1
20.	Clinical teachers plan their teaching ahead so that ward staff can make the necessary arrangements.	5	4	3	2	1
21.	Clinical teachers really belong to the wards rather than the college of nursing.	5	4	3	2	1
22.	Tutors don't seem to get to know the clinical teachers very well.	5	4	3	2	1
23.	It is not realistic to expect the clinical teachers to plan their ward teaching with the ward sisters.	5	4	3	2	1
24.	Clinical teachers spend too much time in the college.	5	4	3	2	1
25.	Clinical teachers should keep a record of how they spend their time.	5	4	3	2	1
26.	The clinical teacher and the ward sister should plan the ward teaching together.	5	4	3	2	1
27.	The clinical teacher should let sister know what he/she wants to do and with which learner he/she wants to work.	5	4	3	2	1

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

28.	The trained staff and the clinical teacher do arrange to share the teaching between them.	5	4	3	2	1
29.	Clinical teachers do not really work as part of the teaching team.	5	4	3	2	1
30.	The clinical teacher does let sister know what he/she wants to do and with which learner he/she wants to work beforehand.	5	4	3	2	1
31.	The clinical teacher should plan his/her teaching ahead so that ward staff can make the necessary arrangements.	5	4	3	2	1
32.	There is not much contact between clinical teachers and tutors.	5	4	3	2	1
33.	Clinical teachers really belong more the college than to the wards.	5	4	3	2	1
34.	Clinical teachers and tutors work well together.	5	4	3	2	1
35.	It is not possible to arrange beforehand what a clinical teacher will do in the ward.	5	4	3	2	1
36.	Clinical teachers do not seem to be very well thought of by ward staff.	5	4	3	2	1
37.	The trained staff and the clinical teacher should discuss the learners' progress together.	5	4	3	2	1
38.	The clinical teacher tells the trained staff what he/she has been doing with the learners.	5	4	3	2	1
39.	Trained staff don't need to teach so much if there is a clinical teacher attached to the ward.	5	4	3	2	1

40. Are you a Registered Clenical Teacher? yes 1
no 2

A. Can you suggest any things which clinical teachers do which you think they should not be doing?

B. Can you suggest any things which you think clinical teachers should be doing which they are not at present doing?

(f) Clinical teachers' questionnaire

CLINICAL TEACHING STUDY

Clinical Teacher No C

Please read each of the following statements and consider whether you would agree or disagree with it. Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase which most closely expresses your opinion, i.e. 5 for 'strongl agree'; 4 for 'agree'; 3 for 'not sure'; 2 for 'disagree' or 1 for 'strongly disagree'.

When you have completed it, the questionnaire, which will be treated confidentially, should be returned to me.

Thank you for your help.

C.M. Robertson

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

1.	Trained staff don't teach so much if there is a clinical teacher attached to the ward.	5	4	3	2	1
2.	Learners would rather seek information and help from ward staff than from a clinical teacher.	5	4	3	2	1
3.	Learners find it difficult to think of the clinical teacher as really being a nurse.	5	4	3	2	1
4.	Ward staff see the clinical teacher as helping to raise the standard of nursing care.	5	4	3	2	1
5.	The sister and the clinical teacher should plan the ward teaching together.	5	4	3	2	1
6.	The clinical teacher's professional ability is questioned by ward staff.	5	4	3	2	1
7.	Learners would rather seek information and help from the tutors than from the clinical teacher.	5	4	3	2	1
8.	Clinical teachers really belong to the wards rather than the college of nursing.	5	4	3	2	1
9.	Other staff think that trained staff are more essential to the teaching of nurses than clinical teachers are.	5	4	3	2	1
10.	Other staff think that tutors have a more essential part in teaching nurses than clinical teachers have.	5	4	3	2	1
11.	I do not have much say or influence with ward staff.	5	4	3	2	1
12.	I do not have much say or influence with teaching staff.	5	4	3	2	1
13.	My general programme of teaching is controlled by the school.	5	4	3	2	1
14.	The tutors indicate which learners should be given most clinical teaching.	5	4	3	2	1
15.	The tutors know what pattern of clinical teaching is needed and I fit in with it.	5	4	3	2	1
16.	The tutors arrange my college commitments and ward teaching is fitted round them.	5	4	3	2	1
17.	I discuss the learner's progress with the trained staff.	5	4	3	2	1
18.	The clinical teacher should plan his/her teaching ahead so that ward staff can make the necessary arrangements.	5	4	3	2	1
19.	The clinical teacher should let sister know what he/she wants to do and with which learner he/she wants to work beforehand.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

20.	I just get on with ward teaching without any guidance from the tutors.	5	4	3	2	1
21.	Sister tells me which learners need help and I work with them.	5	4	3	2	1
22.	The ward sister allocates the work and I just fit in.	5	4	3	2	1
23.	I do things the way the ward sister says she likes them done.	5	4	3	2	1
24.	Sister should tell the clinical teacher which learners need help so that he/she can work with them.	5	4	3	2	1
25.	I let sister know beforehand what I want to do and with which learner I want to work.	5	4	3	2	1
26.	I plan my teaching ahead so that the ward staff can make the necessary arrangements.	5	4	3	2	1
27.	The ward sister and the clinical teacher should arrange to share the ward teaching between them.	5	4	3	2	1
28.	I feel free to discuss with sister anything in the ward which I feel could be improved.	5	4	3	2	1
29.	Sister and I plan the ward teaching together.	5	4	3	2	1
30.	I find that I am very tied to routine tasks.	5	4	3	2	1
31.	I do not have as much control over my own work as I would like to have.	5	4	3	2	1
32.	I have plenty of opportunity to use my own initiative.	5	4	3	2	1
33.	Clinical teachers spend too much time in college.	5	4	3	2	1
34.	I find the job frustrating.	5	4	3	2	1
35.	Contact with the learners compensates for any dissatisfaction I feel in the job.	5	4	3	2	1
36.	Contact with patients compensates for any dissatisfaction I feel in the job.	5	4	3	2	1
37.	Other staff think that the clinical teacher has a wider, more lasting influence on the learner than ward staff have.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

38.	The trained staff and the clinical teacher should discuss the learners' progress together.	5	4	3	2	1
39.	It is unrealistic to expect clinical teachers to spend most of their time giving patient care with learners.	5	4	3	2	1
40.	Trained staff don't need to teach so much if there is a clinical teacher attached to the ward.	5	4	3	2	1
41.	The trained staff tell the clinical teacher what they have been telling/showing the learner	5	4	3	2	1
42.	The way the wards are organised makes it impossible for me to teach in the way that I would like to.	5	4	3	2	1
43.	Clinical teachers should be guided by tutors about which learners to teach most in the wards.	5	4	3	2	1
44.	Clinical teachers really belong more the college than to the wards.	5	4	3	2	1
45.	Clinical teachers should not as a rule be taking learners away from the bedside to give them tutorials.	5	4	3	2	1
46.	I find it difficult to get the information I need from the ward staff to do the job properly.	5	4	3	2	1
47.	I cannot satisfy anyone in this job.	5	4	3	2	1
48.	Sister allocates the work and the clinical teacher should just fit in.	5	4	3	2	1
49.	The sister and I arrange to share the ward teaching between.	5	4	3	2	1
50.	I would like to leave clinical teaching if I could.	5	4	3	2	1
51.	Clinical teaching is a rather lonely job.	5	4	3	2	1
52.	There is not much contact between clinical teachers and tutors.	5	4	3	2	1
53.	Now that I am a clinical teacher I don't feel that I am part of the hospital to the same extent as I used to.	5	4	3	2	1
54.	Although I am no longer part of the ward staff I still have satisfying contacts with patients.	5	4	3	2	1
55.	Now that I am a clinical teacher I don't have as much contact with medical staff as I would like.	5	4	3	2	1
56.	Other staff think that the clinical teacher has a wider, more lasting influence on the learner than tutors have.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

57.	Out of working hours I have close contacts with some members of the ward staff.	5	4	3	2	1
58.	Out of working hours I have close contacts with some members of the teaching staff.	5	4	3	2	1
59.	I do not get much support from the nurse tutors.	5	4	3	2	1
60.	The clinical teachers and the tutors work well together.	5	4	3	2	1
61.	The clinical teachers don't really work as part of the teaching team.	5	4	3	2	1
62.	Clinical teachers are not in the ward often enough to have any real impact on ward teaching.	5	4	3	2	1
63.	Clinical teachers do not seem to get to know tutors very well.	5	4	3	2	1
64.	Clinical teachers should confine themselves to ward teaching.	5	4	3	2	1
65.	Clinical teachers should assist in the whole work of the school.	5	4	3	2	1
66.	Clinical teaching is just a preparation for becoming a tutor.	5	4	3	2	1
67.	The same person cannot combine classroom teaching and ward teaching adequately.	5	4	3	2	1
68.	Ward teaching is more difficult than classroom teaching.	5	4	3	2	1
69.	Clinical teachers really should be very experienced nurses.	5	4	3	2	1
70.	To do the job properly clinical teachers really need to have been ward sisters/charge nurses.	5	4	3	2	1
71.	It is helpful if learners know beforehand that a clinical teacher will be working with them.	5	4	3	2	1
72.	It is not realistic to expect clinical teachers to plan their teaching with the ward staff.	5	4	3	2	1

(g) Clinical teacher interview schedule

CLINICAL TEACHING STUDY

Please complete this page by circling the appropriate number/numbers or writing the answer in the space provided.

Name ..... No.

1. How long have you been in this post?

2. Marital status
   - single 1
   - married 2
   - separated/divorced 3

3. If you have children please indicate their age groups
   - 0 - 5 yrs 1
   - 6 - 10 yrs 2
   - 11 - 15 yrs 3
   - 16 - 20 yrs 4
   - over 20 yrs 5

4. Centre at which clinical teacher course was taken

   .....

5. Year of the course .....

6. Before taking this course were you a
   - staff nurse 1
   - sister/charge nurse 2
   - unqualified nurse teacher 3
   - nursing officer 4

7. In which field?
   - general medicine 1
   - general surgery 2
   - I.C.U., coronary care, neurosurgery 3
   - casualty, acute admissions, theatre, O.P.D. 4
   - psychiatry 5
   - mental handicap 6
   - community 7
   - night duty 8
   - other (please specify) 9

8. How long were you in that post?

9. Prior to that had you held any post at sister/charge nurse level?

Yes	1
No	2

10. If 'yes', what was your total time at this level? (including 8 above if appropriate)

1 - 2 yrs	1
3 - 4 yrs	2
5 - 6 yrs	3
7 - 8 yrs	4
9 - 10 yrs	5
over 10 yrs	6

11. In which fields?

general medicine	1
general surgery	2
I.C.U., coronary care, neurosurgery	3
casualty, acute admissions, theatre, O.P.D.	4
psychiatry	5
mental handicap	6
community	7
night duty	8
other (please specify)	9

12. Did you have any contact with a clinical teacher during your own training?

    During staff nurse or ward sister experience?

    What was your impression of it?

13. Is your allocation to specific wards? Which specialties? Groups of learners? How many wards do you cover? Approximately how many patients?

14. Were you involved in the decision to work that way?

15. Which hours do you normally work?

    Do you ever work with learners in the evenings/at night/at weekends?

    Are there any particular reasons why you do/do not work at these times?

16. Has the possibility of working at these times ever been discussed with your senior tutor/DNE?

17. How do you decide how your time should be divided between wards/sections?

18. How do you decide which students/pupils will receive clinical teaching?

    (a) random choice/availability;
    (b) attempt to see every student;
    (c) specific stages in training;
    (d) those who most seem to need it;
    (e) those who seem most to want it;
    (f) decided after discussion with ward staff.

19. Do the learners themselves ever seek you to work with them?

20. On average how often do you manage to see each learner?

21. How long do you usually spend with each learner at a time?

22. What do you think are the ideal length and frequency of contact?

23. Do you try to plan your day's work in advance?

24. How do you do this? Do you make arrangements with the ward sister? the learners?

25. To what extent is it possible to plan more than one day ahead?

26. How easy is it to check on the learners' previous experience and teaching?

27. Can you rank these activities in order of the amount of time which you spend on each, giving (1) to the one which you do most often and on which you spend most time, and (5) to the one which you do least often and on which you spend least time?

(a) carry out specific procedures with different individual learners;
(b) work with one learner to complete all the tasks which have been allocated to her or to you both?
(c) care for all the needs of individual patients with a learner?
(d) take a group of learners together to discuss specific topics?
(e) discuss specific topics with individual learners.

28. Would you like to be able to change this order at all?

29. How do you find out what has been happening to the patients from day to day?

30. Do you find that ward staff are interested in what you are doing with learners?

31. Is there any discussion with ward staff about the teaching they do?

32. How would you rate the job satisfaction gained from ward based teaching?

(a) very high; (b) fair; (c) fair; (d) low; (e) very low.

34. Approximately how much time did you spend last week on:

(a) arranging ward teaching;
(b) record keeping;
(c) discussions with ward staff;
(d) discussions with tutorial staff;
(e) teaching in the practical/ demonstration room;
(f) informal counselling;
(g) participating in formal assessment of learners;
(h) committees/meetings;
(i) preparation (including reading to keep up to date);
(j) other activities, specify.

35. Approximately how much of your time is spent on teaching in the classroom? Is this a regular commitment?

36. How would you rate the job satisfaction gained from non-ward based teaching?

very high / high / fair / low / very low?

37. Do you feel that one person can do justice to both kinds of teaching?

38. How much contact do you have with nursing administration?

39. Do you think that they give you enough support?

40. How much contact do you have with - nurse teachers?
- clinical teachers?

41. Do you feel that you get enough support from your Senior Tutor/DNE?

42. How does your Senior Tutor monitor/your work?

43. What do you see as the principal attractions of this job?

44. What are its particular problems?

45. Which of the following statements most nearly expresses your feeling about the job as a whole?

(a) I am very satisfied with it;
(b) it is not ideal but I will probably stick to it for some time to come;
(c) it is not ideal and I will probably go on to something else in the near future;
(d) it is unsatisfactory and I will get out as soon as I can;
(e) it is fairly satisfactory but I expect to move on to something else in due course.

46. What do you think you might go on to next?

(h) Director of Nurse Education interview schedule

CLINICAL TEACHING STUDY

Code No

1. Types of training offered Numbers of Learners

2. Number of tutors in post:-

   D.N.E.
   Senior Tutors
   Tutors

3. Number of clinical teachers in post:- full time? part time?

Organisation of Clinical Teaching

4. Are the clinical teachers allocated to: wards? groups of learners?

   How many wards? How many learners?

5. How much choice did the CT have?

6. What hours do the clinical teachers work?

   Do they ever work with learners in the evenings? at night?
   at weekends?

   Whose decision would this be?

Planning and implementation of clinical teaching

7. How would you expect a clinical teacher to decide how her time should be divided between wards/sections?

8. To what extent would you expect a CT to be able to plan her work ahead?

9. How would you expect a clinical teacher to decide which students/ pupils should receive clinical teaching?

   (a) random choice/availability
   (b) attempt to see every learner?
   (c) see those at specific stages of training?
   (d) see those who most need it?
   (e) see those who most seem to want it?

10. How much discussion would you expect between the CT and the ward sister about the needs of learners in the ward? about choice of teaching activity/topic?

11. Are there any learning objectives prepared for the wards?

    By whom were they prepared?

    Does this mean that there is an overall plan of teaching?

12. Roughly how much time would you expect a clinical teacher to spend on each of these activities in a week?

    (a) arranging ward teaching;
    (b) record keeping;
    (c) discussions with ward staff;
    (d) discussions with tutorial staff;
    (e) teaching in the practical/demonstration room;
    (f) informal counselling;
    (g) in-service training;
    (h) formal assessments;
    (i) committee meetings;
    (j) preparation (including reading to keep up to date)
    (k) other activities.

13. Can you rank these activities in order of the amount of weight your clinical teachers put on them?

    (a) carrying out specific procedures with particular learners.
    (b) working with one learner to complete the tasks allocated to her.
    (c) caring for individual patients with a learner.
    (d) taking groups of learners together to discuss specific topics.
    (e) discussing specific topics with individual learners.

    Now can you rank them in the order in which <u>you would like</u> your clinical teachers to weight them?

14. How much teaching does each learner get?

15. How do you keep yourself informed about what the clinical teachers are doing?

16. What kind of control do you have of the clinical teaching?

17. Approximately how much classroom teaching do the clinical teachers do?

18. To what extent do you think that they can teach both in the classroom and at the bedside?

19. Do you expect the clinical teachers to be accepted by the ward staff as part of the ward team or to be identified with tutors as part of the teaching team?

20. It is always said that ward staff do not want them and can't get on with them. Do you think that is really a problem?

21. How much contact do they have with the tutors?

22. What kind of support do the clinical teachers need?

23. How can this be provided?

24. How much involvement is it feasible for them to have in the non-teaching activities of the college?

25. How much freedom do the clinical teachers have to plan and organise their teaching for themselves?

26. What do you think are the most problematical aspects of the job?

Appendix 6

Letters, questionnaires and interview schedules

used in the survey

(a) Letter to Directors of Nurse Education

(b) Letter to clinical teachers

(c) The survey questionnaire

(d) Letter to clinical teachers requesting an interview

(e) Interview schedule

(a) Letter to Directors of Nurse Education

Dear

Clinical Teaching Study

Over the past few years I have been undertaking a study of the development and practice of clinical teaching. The present stage of this study is concerned with the career patterns of clinical teachers and the ways in which clinical teaching is organised and implemented.

I am writing now to inform you of the study and to ask your permission to invite your clinical teachers to participate in it by completing a questionnaire, which will take approximately half an hour.

If you are agreeable I would be grateful if you would let me have a list of the clinical teachers (excluding midwifery) on your staff and their postal addresses so that I can make a personal approach to them. Any information which they give me will be treated as confidential and when the final report is prepared care will be taken to ensure that anonymity is maintained.

If you would like any further information I would be happy to provide it or come and talk to you about the study.

With many thanks for your help.

Yours sincerely,

Miss C.M. Robertson,B.A.,R.G.N.,S.C.M.,R.C.N.T.,R.N.T.
Lecturer

(b) Letter to clinical teachers

Dear

Since becoming Course Leader of the clinical teacher's course offered by this college I have been increasingly interested in the different ways in which clinical teacher has been developing and over the past few years I have been undertaking a study of various aspects of the development and practice of clinical teaching. The present stage of this study is concerned with the career patterns of clinical teachers and the ways in which clinical teaching is organised and implemented.

I am writing now to invite you to take part in this study by completing the enclosed questionnaire and returning it to me in the envelope provided. Participation is entirely voluntary and any information which you give me will be treated as confidential.

It would be helpful if you would return the questionnaire as soon as possible and preferably within the next two weeks.

Many thanks for your help.

Yours sincerely,

Miss C.M. Robertson,B.A.,R.G.N.,S.C.M.,R.C.N.T.,R.N.T.
Lecturer

Enc.

(c) The survey questionnaire

CLINICAL TEACHING STUDY

Please complete this section by writing the answers in the spaces provided or by circling the appropriate number/numbers.

1. Year of initial registration as a nurse?

2. Which other statutory qualifications do you hold?

further registration	1
midwifery	2
district nursing	3
health visiting	4

3. Have you held any posts at ward sister/charge nurse level?

yes	1
no	2

4. If 'yes', for how long altogether?

if you have worked as a nurse overseas, or in the armed forces, please exclude this time but insert the number of years in the box provided.

Years overseas/forces ☐

1 - 2 years	1
3 - 4 years	2
5 - 6 years	3
7 - 8 years	4
9 - 10 years	5
over 10 years	6

5. Immediately before starting the clinical teachers' course were you a

staff nurse	1
sister/charge nurse	2
unqualified nurse teacher	3
nursing officer	4
other (please specify)	5

6. In which field was your most recent clinical appointment? (i.e. sister/staff nurse)

general medicine	1
general surgery	2
I.C.U., coronary care,	3
neurosurgery, neurology	4
casualty/theatre/C.P.D.	5
mental handicap	6
psychiatry	7
night duty	8
other (please specify)	9

7. For how long were you in that post?

8. If you hold any qualifications in that field, other than those identified in question 2, please indicate which ones.

9. At which centre did you take the clinical teachers' course?

10. In which year did you qualify as a clinical teacher?

11. Have you worked continuously as a clinical teacher since then?
Yes 1
No 2

12. If not, what other posts have you held since qualifying as a clinical teacher?

13. When you decided to obtain a clinical qualification did you -

(a) intend to use it as a step towards some other qualification/work? 1

(b) expect to work as a clinical teacher for some considerable time? 2

(c) intend to work as a clinical teacher while you were making up your mind what to do next? 3

14. Now, would you like to

(a) leave clinical teaching as soon as possible? 1

(b) go on working as a clinical teacher for a few years yet? 2

(c) work as a clinical teacher for the foreseeable future? 3

15. If you answered (a) or (b) to question 14, what do you hope to do next?

Individual clinical teachers have very different remits. The following questions are designed to give a broad picture of the pattern of work of clinical teachers throughout Scotland. If you do not feel that they allow an adequate summary of your own remit please feel free to give additional information in the space provided at the bottom of page 8.

16. Which of the following best describes your remit?

(a) most of my time is given to teaching in the college. 1

(b) my time is approximately equally divided between teaching in the college and ward teaching. 2

(c) less than half of my time is given to teaching in the college. 3

---

17. In which way, if any, would you like to change this? Can you give reasons?

---

18. If half of your time or less is spent on teaching in the college, can you indicate approximately how many hours you spent in college/classroom teaching last week? hrs

---

19. Was this ..... more than usual? 1
about average? 2
less than usual? 3

---

20. Was this teaching related to

(a) a particular module? (please specify) 1

(b) a particular subject area? (please specify) 2

(c) a particular group of learners? (please specify) 3

---

21. Which of (a), (b), (c) above are regular commitments?

(a) 1
(b) 2
(c) 3

---

22. Which of the following statements most accurately describes your remit?

(a) I go with specific groups of learners to most of the wards to which they are allocated. 1

(b) I am allocated to specific wards in one hospital. 2

(c) I work in one specialty and this includes wards in more than one hospital. 3

(d) I am allocated to all of the wards in one hospital. 4

(e) Other, please specify. 5

---

23. If you do not teach in all of your allocated wards regularly please indicate how the choice is made.

24. Which medical specialties are included in the wards in which you regularly teach?

general medicine	1
general surgery	2
neurosurgery/neurology	3
paediatrics	4
psychiatry	5
mental handicap	6
gynaecology	7
orthopaedics	8
other (please specify)	9

25. How many wards are in your allocation?

26. Approximately how many patients are there altogether in the wards in which you regularly teach?

27. How many learners altogether are there this week in the wards in which you regularly teach?

28. Is this number ..... more than usual? 1
about average? 2
less than usual? 3

29. On which committees, if any do you serve?

30. Do you have a regular commitment to any of the following?

marking written examinations	1
supervision of projects/care studies	2
practical/oral assessment of learners	3
orientation of new staff	4
recruitment, selection or orientation of candidates	5
conducting learners on visits outside your own area	6
administration, other than that related to your teaching	7

31. Do you have an office in the ..... college of nursing 1
main hospital in which you teach 2

32. Do you share your office/s with other clinical teachers?

33. How many other clinical teachers work in the main hospital in which you teach?

34. Ideally, do you think the optimum number of contacts with each learner would be

daily?	1
several times a week?	2
once a week?	3
once in two weeks?	4
less often?	5

35. Ideally, what do you think, on average, is the optimum time to spend with each learner at any one time?

15 - 30 mins	1
30 - 45 mins	2
45 - 60 mins	3
1 - 2 hours	4
over 2 hours	5

Name

College Code number

These are for the researcher's use only.

The next section is about the way you would like clinical teaching to be, irrespective of whether or not you are actually able to practice in that way at the moment. You are given a list of statements with which you are asked to agree or disagree. The statements are in a random sequence and you are asked to give your immediate reaction. You should not take time to think about them.

Please circle the appropriate number for each statement, according to the following code:

5 strongly agree 4 agree 3 not sure 2 disagree
1 strongly disagree

1.	While working with individual patients with a learner clinical teachers should always refer any decisions about the patient's nursing care to the nurse in charge.	5	4	3	2	1
2.	Clinical teachers should assist in the whole work of the college.	5	4	3	2	1
3.	The clinical teacher should not expect the routine of the ward to be altered to accommodate his/her teaching.	5	4	3	2	1
4.	The clinical teacher should really work as part of the teaching team.	5	4	3	2	1
5.	Clinical teachers should not be expected to spend most of their time giving patient care with learners.	5	4	3	2	1
6.	To do the job properly clinical teachers really need to have been ward sisters/ charge nurses.	5	4	3	2	1
7.	It is helpful if learners know beforehand that a clinical teacher will be working with them.	5	4	3	2	1
8.	The clinical teacher should see his/her main responsibility as supervising, demonstrating, and explaining nursing procedures.	5	4	3	2	1
9.	Clinical teachers should be very experienced nurses.	5	4	3	2	1
10.	The clinical teacher should let sister know beforehand with which learner he/she wants to work.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 strongly agree 4 agree 3 not sure 2 disagree
1 strongly disagree

11.	The clinical teacher should concentrate on teaching first year learners in the clinical areas.	5	4	3	2	1
12.	Trained staff don't need to teach so much if there is a clinical teacher attached to the ward.	5	4	3	2	1
13.	Clinical teachers should really belong to the wards rather than the college of nursing.	5	4	3	2	1
14.	Clinical teachers do not need to plan their teaching with the ward staff.	5	4	3	2	1
15.	Clinical teachers are not in the wards often enough to have any real impact on ward teaching.	5	4	3	2	1
16.	When working with individual patients with learners clinical teachers should make decisions about the patient's nursing care.	5	4	3	2	1
17.	Clinical teaching should be seen as a preparation for becoming a tutor.	5	4	3	2	1
18.	The sister and the clinical teacher should arrange to share the ward teaching between them.	5	4	3	2	1
19.	Clinical teachers should not as a rule be taking learners away from the bedside to give them tutorials.	5	4	3	2	1
20.	The same person can combine classroom teaching and ward teaching adequately.	5	4	3	2	1
21.	The sister and the clinical teacher should plan the ward teaching together.	5	4	3	2	1
22.	Clinical teachers spend too much time in college.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 strongly agree 4 agree 3 not sure 2 disagree
1 strongly disagree

23.	It is impossible for the clinical teacher to take a 'patient-centred' approach with a learner if the ward does not operate in this way.	5	4	3	2	1
24.	Clinical teachers should really belong more to the college than to the wards.	5	4	3	2	1
25.	The clinical teacher should let sister know what he/she wants to do beforehand.	5	4	3	2	1
26.	Clinical teachers should be involved in teaching newly qualified trained staff.	5	4	3	2	1
27.	The clinical teacher should see his/her main responsibility as advising, supporting and guiding learners while working with patients.	5	4	3	2	1

(d) Letter to clinical teachers requesting an interview

Dear

Clinical Teaching Study

Thank you very much for completing my questionnaire earlier this year. I was very encouraged by the interest and enthusiasm with which it was received. 84% of the clinical teachers to whom it was sent responded and as a result I have been able to demonstrate the great variation in the ways in which clinical teaching is organised and implemented in Scotland. I am hoping that the study will be completed by the spring or early summer and that by then some information about the findings can be made available to those who have helped with the study. In the meantime I would like to explore some aspects of the organisation of clinical teaching in more depth than is possible using a postal questionnaire. For this purpose I would like the opportunity to talk to a sample of those who completed the questionnaire and so I am trying to arrange a series of interviews over the next few weeks. Each interview would probably last for about 1-1½ hours, although it is difficult to be exact about this, and it would be helpful if the clinical teacher being interviewed could arrange for us to meet in some fairly quiet place either in the college or the hospital.

If you would be willing to participate in this way would you please complete the enclosed form giving me a choice of three times when you will be available. I will then draw up my programme and contact you again. It can sometimes be difficult to locate clinical teachers at short notice so if there is a place and a time at which you can readily be contacted by telephone this information will be appreciated.

As with the questionnaire the interviews will be strictly confidential and although I have asked the D.N.E.s for permission to approach their clinical teachers I have not indicated which individuals I will be inviting to take part.

If you feel that you would rather not participate in this part of the study, perhaps you would be good enough to return the blank form to me.

Many thanks for your help.

Yours sincerely,

Miss C.M. Robertson
Lecturer

(e) Interview schedule

College teaching

Other college work -

- exam/assess
- written papers
- project/care study
- candidates
- visits/orientation
- committees/meetings
- other

Specialty

Own experience

Wards - number/size
sites/distance
number/spread learners
type of learners

Time with learners

Regular

First year/new staff nurse

Nature of teaching -

- assist/comp w/s
- relieve w/s
- share teaching

Content of teaching -

- procedures -
  - demo/super/epl
- patient -
  - share care
  - advise/support
- tutorials

Method of working

Access to information

Easier to work in some wards than others

- ward organisation
- staffing
- workload
- duty rotas

Patient centred approach

Relations with ward staff

- subordinate to w/s - decisions
- CT autonomous

Other learners contact -

- counselling
- assessment

Admin ward teaching -

- preparation - reading
  with w/s
  up-date
- planning - overall/ward objectives
  each episode
  own day/week
  with w/s
- liaison - let w/s know
  learner know
  other service
  tutors

Records

Experienced ward sister

Transient/permanent

BIBLIOGRAPHY

A large number of primary and secondary sources have been referred to in the report of the historical study in Part 2 and details of these are given at the ends of the appropriate chapters. For the sake of simplicity only books and published reports are repeated here.

As in the references, where reports are normally known by their chairman's name this is included after the title.

Abel-Smith B. (1960) A History of the Nursing Profession Heinemann Ltd. London

Alexander M.E. (1980) Nurse Education; an experiment in integration of theory and practice in nursing PhD Thesis University of Edinburgh

Barclay James (1946) Why no nurses? Faber and Faber London

Batey M.V. (1971) Conceptualising the Research Process Nursing Research 20:4 pp 296-301

Batey M.V. (1977) Conceptualization: knowledge and logic guiding empirical research Nursing Research 26:5 pp 324-329

Bechhoffer F. (1974) Current Approaches to Empirical Research: some central ideas in Rex J. (Ed) Approaches to Sociology Routledge and Kegan Paul London

Becker H.S., Geer B., Hughes E.C., Strauss A.L. (1961) Boys in White University of Chicago Press Chicago

Becker H.S. (1970) Sociological Work Aldine United States

Bellaby P., Oribabor P. (1980) The History of the Present: contradiction and struggle in nursing in Davies C. (Ed) Rewriting Nursing History Croom Helm London

Bendall E. (1975) So You Passed Nurse Rcn London

Ben-David J. (1958) The Professional Role of the Physician in Bureaucratized Medicine: a study in role conflict Human Relations 11:3 pp 255-274

Benne K.D., Bennis W. (1959) Role Confusion and Role Conflict in Nursing: what is real nursing? American Journal of Nursing 59:3 pp 380-383

Bloch M. (1954) The Historian's Craft Manchester University Press Manchester

Bogdan R., Taylor S.J. (1975) Introduction to Qualitative Research Methods Wiley New York

Bulmer M. (1979) Concepts in the Analysis of Qualitative Data Sociological Review 27:4 pp 651-677

Byerly E.L. (1969) The Nurse as Participant-Observer in a Nursing Setting Nursing Research 18:3 pp 230-236

Carpenter M. (1980) Asylum Nursing Before 1914: a chapter in the history of labour in Davies C. (Ed) Rewriting Nursing History Croom Helm London

Carr E.H. (1961) What is History? McMillan London

Carter G.B. (1939) A New Deal for Nurses Gallancz London

Chapman C.M. (1972) Clarify the Concepts Nursing Times 68:5 pp 775-776

Clark Kitson G.R. (1967) The Critical Historian Heinemann London

Clark J. (1973) A Family Visitor Rcn London

Cohen J. (1948) Working Party on Recruitment and Training of Nurses : minority report H.M.S.O. London

Committee on Senior Nursing Staff Structure (1966) Report (Salmon Committee Report) H.M.S.O. London

Cormack D. (1976) Psychiatric Nursing Observed MPhil Thesis Dundee College of Technology

Crawford G., Dufault K., Rudy E. (1979) Evolving Issues in Theory Development Nursing Outlook (May) p 346-351

Dan Mason Nursing Research Committee (1956) The Work of Recently Qualified Nurses Dan Mason London

Davies C. (1977) Continuities in the Development of Hospital Nursing in Britain Journal of Advanced Nursing 2:5 pp 479-493

Davies C. (1980) Rewriting Nursing History Croom Helm London

Department of Health for Scotland: Scottish Health Services Council (1955) The Work of Nurses in Hospital Wards H.M.S.O. Edinburgh

Dickoff J., James P. (1968) A Theory of Theories: a position paper Nursing Research 17:3 pp 197-203

Dickoff J., James P., Semradek J. (1975) 8-4 Research Part 1 A Stance for Nursing Research - tenacity or enquiry Nursing Research 24:2 pp 84-88

Dickoff J., James P. (1975) Theory Development in Nursing in Verhonick P. (Ed) Nursing Research Little, Brown & Co. Boston

Dingwall R. (1977) The Social Organisation of Health Visitor Training Croom Helm London

Dodd A.P. (1973) Towards an Understanding of Nursing PhD Thesis University of London

Donaldson S.K., Crowley D.M. (1978) The Discipline of Nursing Nursing Outlook 26 pp 113-120.

Dutton A. (1968) Factors Affecting Recruitment of Nurse Tutors King's Fund London

Elton G.R. (1967) The Practice of History Methuen London

Fox D.J. (1976) Fundamentals of Research in Nursing Appleton-Century-Crofts New York

Fretwell J.E. (1978) Socialisation of Nurse Teaching and Learning in Hospital Wards PhD Thesis University of Warwick

Friedrichs J., Lüdtke H. (1975) Participant Observation Saxon House Aldershot

General Nursing Council (1975) Teachers of Nursing 1 & 2 G.N.C. London

General Nursing Council for Scotland (1978) Schemes of Training for the Register of Nurses G.N.C. Edinburgh

General Nursing Council for Scotland (1979) Training for the Roll of Nurses G.N.C. Edinburgh

Glaser B., Strauss A. (1965) Awareness of Dying Aldine United States

Glaser B. (1965) The Constant Comparative Method of Qualitative Analysis Social Problems 12 pp 436-445

Glaser B., Strauss A. (1968) The Discovery of Grounded Theory Weidenfeld & Nicolson London

Glaser B. (1978) Theoretical Sensitivity Sociology Press California

Goddard H.A. (1958) Principles of Administration Applied to Nursing Practice W.H.O. Monograph Series No.41 W.H.O. Geneva

Gold R.L. (1958) Roles in Sociological Field Observations Social Forces 36:3 pp 217-223

Gouldner A.W. (1956) Explorations in Applied Social Science Social Problems 3 pp 169-181

Grypdonck M.H. (1980) Theory and Research in a Practice Discipline: the case of nursing PhD Thesis University of Manchester

Hall P., Laird H., Parker R., Webb A. (1975) Change, Choice and Conflict in Social Policy Heinemann London

Jacox A. (1973) Theory Construction in Nursing: an overview Nursing Research 23:1 pp 4-13

Johnson M. (1983) Some Aspects of the Relations Between Theory and Research in Nursing Journal of Advanced Nursing 8 pp 21-28

King I.M. (1975) A Process of Developing Concepts for Nursing Through Research in Verhonick P.S. (Ed) Nursing Research Little, Brown & Co. Boston

Lancet Commission on Nursing (1932) Report Lancet Ltd London

Lazarsfeld P. (1972) Qualitative Analysis Alyn & Bacon Inc.

Lofland John (1971) Analyzing Social Settings: a guide to qualitative observation and analysis Wadsworth Publishing Co. United States

McCall G.J., Simmons J.L. (1968) Issues in Participant Observation Addison Wesley Publishing Co. Massachusets

McFarlane E.A. (1980) Nursing Theory: the comparison of 4 theoretical proposals Journal of Advanced Nursing 5:1 p 3-19

McFarlane J.K. (1977) Developing a Theory of Nursing: the relation of theory to practice, education and research Journal of Advanced Nursing 2:3 pp 261-270

Maggs C. (1980) Nurse Recruitment to Four Provincial Hospitals 1881-1921 in Davies C. (Ed) Rewriting Nursing History Croom Helm London

Mauksch H.O. (1965) Becoming a Nurse: a selective view in Skipper J.K. and Leonard R.C. Social Interaction and Patient Care Lippincott

Melia K. (1981) Student Nurses' Accounts of their Work and Training: a qualitative analysis PhD Thesis University of Edinburgh

Ministry of Health, Department of Health for Scotland, General Nursing Council, General Nursing Council for Scotland (1954) The Function, Status and Training of Nurse Tutors H.M.S.O. London

Nightingale F. (1959) Notes on Nursing Duckworth London

Nuffield Provincial Hospitals Trust (1953) The Work of Nurses in Hospital Wards: report of a job analysis Nuffield Provincial Hospitals Trust London

Nurses, Midwives and Health Visitors Act (1979) H.M.S.O. London

Nurses and Midwives Whitley Council (1976) Pay and Conditions of Service H.M.S.O. London

Nursing Reconstruction Committee (1943) Report II Education and Training (Horder Committee) Rcn London

Ogier M.E. (1979) A Study of the Leadership Style and Verbal Interaction of Ward Sisters with Nurse Learners PhD Thesis Birbeck College London University

Oppenheim A.N. (1976) Questionnaire Design and Attitude Measurement Heinemann London

Orton H.D. (1979) Ward Learning Climate and Student Nurse Response MPhil Thesis Sheffield City Polytechnic

Oxford Regional Hospital Board (1956) Training of Nurses in General Hospitals Oxford R.H.B.

Pearsall M. (1965) Participant Observation as Role and Method in Behavioural Research Nursing Research 14:1 pp 37-42

Phillips D. (1971) Knowledge from What? theories and methods in social research Rand McNally Chicago

Quint J. (1967) The Case for Theories Generated from Empirical Data Nursing Research 16:2 pp 109-114

Rex J. (1974) Approaches to Sociology Routledge and Kegan Paul London

Riehl J.P., Roy C. (1980) Conceptual Models for Nursing Practice Appleton-Century-Crofts New York

Robertson C.M. (1982) A Description of Participant Observation of Clinical Teaching Journal of Advanced Nursing 7:6 pp 549-554

Rosenthal C.J. (1980) Nurses, Patients and Families Croom Helm London

Royal College of Nursing (1953) Memorandum on the Nurse Tutor Rcn London

Royal College of Nursing (1956) Observations and Objectives: a statement on nursing policy Rcn London

Royal College of Nursing: Tutor Section (1961) The Nurse Tutor: a new assessment Rcn London

Rutherford M., Spitzer S.P. (1968) Observer Efforts and Hospital Interaction Nursing Research 17:1 pp 65-68

Schlotfeld R. (1975) The Need for a Conceptual Framework in Verhonick P.J. (Ed) Nursing Research Little, Brown & Co Boston

Schwartz M.S., Schwartz C.G. (1968) Problems in Participant Observation in McCall G.J., Simons S.L. (Eds) Analyzing Social Settings: a guide to qualitative observation and analysis Wadsworth Publishing Co United States

Scottish Departmental Committee on the Training of Nurses (1936) Report Department of Health for Scotland Edinburgh

Scottish Home and Health Department (1963) Experimental Nurse Training at Glasgow Royal Infirmary H.M.S.O. Edinburgh

Seymer L. (1960) Florence Nightingale's Nurses Pitman London

Skellern E. (1953) Report of an investigation carried out "to study, report and make recommendations on the practical application to ward administration of modern methods in the instruction and handling of staff and student nurses Rcn London

Skipper J.K., Leonard R.C. (1965) Social Interaction and Patient Care Lippincott

South East Metropolitan Area Nurse Training Committee (1957) The Work of Student Nurses and Pupil Assistant Nurses S.E. Metropolitan H.N.T.C. London

Stevens B.J. (1979) Nursing Theory: analysis, application, evaluation Little, Brown & Co Boston

Treece E.W., Treece J.W. (1973) Elements of Research in Nursing C.V. Mosby Co St Louis

Towell D.A. (1973) Understanding Psychiatric Nursing PhD Thesis Cambridge University

Verhonick P.J. (1975) Nursing Research Little, Brown & Co Boston

Verluysen M.C. (1980) 'Old Wives' Tales? women healers in English history in Davies C. Rewriting Nursing History Croom Helm

Wald F.S., Leonard R.C.(1964) Towards Development of Nursing Practice Theory Nursing Research 13:4 pp 309-313

Wax R. (1971) Doing Fieldwork University of Chicago Press Chicago

White R. (1980) Social Change and the Development of Nursing Profession Henry Kimpton London

Working Party on Recruitment and Training of Nurses (1946) Report (Wood Committee Report) H.M.S.O. London

APPENDICES

Emerging Questions and Categories

Clinical teachers were intended to work in the wards -

- by whom?
- doing what?

→ Ideal Model

They are not sufficiently ward based, spend too much time in school -

- what is their allocation?
- how much is too much?
- what do they do in the school?

→ Content of Job

Learners are favourable towards clinical teaching but would like more -

- what effect does learner attitude have on clinical teachers?
- how much time does each learner get?

→ Amount of clinical teaching

Clinical teachers not in the wards enough to be the dominant ward teachers -

- should they be?
- is it a matter of time, frequency or what?

→ Influence of clinical teacher

Learners' and ward staff's perception of what learners need and want to be taught differ -

- who decides what they are taught?
- are 'need' and 'want' different?
- why do they need it or want it?

→ Content of teaching

Deployment of clinical teachers differs between colleges and wards -

- why is this so?
- does it matter?

→ Organisation of clinical teaching

Ward sisters impede clinical teachers by preventing access to learners -

- do they know that they are doing so?
- how do they do it?
- why do they do it?
- how much access of what kind is needed?

→ Implementation of clinical teaching

Tutors expect clinical teachers to do college work -

- what kind of college work?
- why do they expect it?
- why should they not expect it?

→ Content of job; expectations

Clinical teachers can neither do what they are 'supposed' nor what they 'should' be doing -

- where do these ideas originate?

→ Ideal Model

There is inadequate differentiation between the work of tutor and clinical teacher -

- is this formal, actual, or both?
- why is it important?

→ Definition of job

There is more agreement between ward sisters and clinical teachers about their respective functions than between tutors and clinical teachers -

- what effects does this have on clinical teachers?
  learners?

→ Attitudes

Clinical teachers do not receive sufficient support from tutors -

- what kind of support?
- how much is sufficient?

→ Organisation/Expectation

Tutors imply that clinical teaching is not as important as 'tutoring' -

how do they imply it? — Attitudes

There is inadequate recognition of the clinical teacher -

what kind of recognition?
why is this important? — Status/self image

Learners see college as where they learn to pass exams and wards as where they learn to become nurses -

what is the relationship between wards and college?
how do other staff perceive it? — Education/service conflict

Clinical teacher is caught up in conflict between service and education -

what form does this conflict take?
how does it affect the learners? — Education/service conflict

Ward staff don't understand what clinical teachers are trying to do -

is this true, or only thought to be so?
what are they trying to do? — Expectations

Quality of ward teaching determined by ward sister not clinical teacher -

how do we know?
in what ways does it matter? — Status/self image

Clinical teacher is considered to be an outside agent -

by whom?
what effects does this have? — Orientation

Clinical teachers not seen by learners to have any authority in the ward -

what effects would this have? — Expectations

Inadequate definition of the clinical teacher's responsibility -

by whom?
in what ways is it inadequate?
what effects does this have? — Responsibility
Influence

Letters, questionnaires and interview schedules used in the exploratory study

(a) Letter to Chief Area Nursing Officer, District Nursing Officer and Principal Tutor

(b) Letter to Clinical Teachers

(c) Letter to trained staff

(d) Learners' questionnaire

(e) Trained staff's questionnaire

(f) Tutors' questionnaire

(g) Clinical teachers' questionnaire

(h) Clinical teachers' interview schedule

(i) Principal Tutor's interview schedule

(a) Letter to Chief Area Nursing Officer, District Nursing Officer and Principal Tutor

Dear

Since becoming course leader of the Clinical Teachers course offered by this College, I have been interested in the different ways in which the clinical teachers' role has been developing and concerned about the rapid turnover of clinical teachers in some areas. About three years ago I began to explore the possibility of developing a research project designed to examine some aspects of the subject.

Since that time I have been registered with the C.N.A.A. as a part-time research student and the project, entitled 'The Development and Practice of Clinical Teaching' is fairly well advanced.

I am writing now to ask permission to invite clinical teachers in your Area and staff with whom they work to take part in this study. The kind of participation which is envisaged is the completion of a questionnaire and an interview lasting approximately one hour for clinical teachers and a similar but shorter procedure for other grades of staff.

If this is agreeable to you I would like to approach the staff of ..... College of Nursing and its associated hospitals, with a view to carrying out an exploratory study.

Perhaps you would let me know if it is in order for me to contact Miss ..... with a view to starting this part of the fieldwork within the next few weeks.

With many thanks.

Yours sincerely,

Miss C.M. Robertson
Lecturer

(b) Letter to Clinical Teachers

Dear

I am currently engaged in a research project entitled 'The Development and Practice of Clinical Teaching', one of the purposes of which is to obtain information about the way in which clinical teaching is being organised and carried out in different hospitals and colleges.

I am writing to invite you to take part in this study, which will take the form of a questionnaire to trained staff, learners, clinical teachers and tutors. In addition I would like to interview clinical teachers and principal tutors. The clinical teachers' questionnaire takes about 15 minutes to complete, the other ones 5-10 minutes. The interview could be completed in one hour. The whole exercise would, of course, be confidential and for this reason I intend to use numbers rather than names for the questionnaire.

I have discussed the project with (District Nursing Officer) and (Principal Tutor) who have given their approval and agreed that I should invite you to take part. If you are willing to do so, perhaps you would let me know within the next few days. I enclose a prepaid envelope for this purpose.

Many thanks.

Yours sincerely,

Miss C.M. Robertson
Lecturer

Enc.

(c) Letter to trained staff

Dear Colleague,

Since becoming Course Leader of the Clinical Teacher's Course offered by this College I have been interested in the different ways in which the clinical teacher's role has been developing and concerned about the rapid turnover of clinical teachers in some areas.

For the last two years I have been developing a research programme designed to investigate some aspects of this subject, and I have been given permission to carry out some of this research in the ..... District.

I am writing now to invite you to take part in this study by completing a questionnaire about clinical teaching. Participation is entirely voluntary and the answers to the questionnaire will be confidential, that is why I have not asked for names on the questionnaires.

It has been agreed that the Clinical Teachers will distribute the questionnaires to the trained staff and learners who are willing to complete them. Please note that there is one questionnaire for learners and one for trained staff of all grades. Neither of the questionnaires should take much more than ten minutes to complete. (Principal Tutor) has agreed that the College of Nursing can be used as the central collecting point and it would be helpful if completed forms could be sent there in the envelopes provided by next Monday so that I can arrange to collect them.

If you would like more information about the study please contact me at the College of Technology. Thank you very much for your help.

Yours sincerely,

Miss C.M. Robertson
Lecturer

(d) Learners' questionnaire

CLINICAL TEACHING STUDY

Learner No

This questionnaire is about your experience of clinical teaching. Please complete the questions about your course and your contacts with clinical teachers by circling the number of the appropriate answer or by writing your answer in the space provided.

Then read the statements 12 - 30 carefully and consider whether, from your experience of clinical teachers, you would agree or disagree with it.

Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase which most closely expresses your opinion, i.e. 5 for 'strongly agree'; 4 for 'agree'; 3 for 'not sure'; 2 for 'disagree'; or 1 for 'strongly disagree'.

I have arranged to collect the envelopes containing the completed questionnaires from the College of Nursing. When you have completed the questionnaire, which will be treated confidentially, it should be sent to the college in the envelope provided.

Thank you for your help.

C M Robertson

Hospital _____ Ward No _____

1. What kind of course are you undertaking?

Enrolment	1
General Registration	2
Psychiatric Registration	3
Other	4

If 'other' please specify .....

---

2. Which year of training have you reached? 1 2 3

---

3. How many clinical teachers have worked with you in this course so far?

---

4. In your present ward, how often do you have contact with a clinical teacher?

---

5. On average, how long does the clinical teacher spend with you?

---

6. When a clinical teacher spends time with you how often is it because you asked for help?

Never	1
Seldom	2
Often	3
Always	4

---

7. How helpful do you find your contacts with the clinical teacher?

Very helpful	1
Helpful	2
Not very helpful	3
Very little help	4
No help at all	5

---

8. What kind of things do you expect the clinical teacher to do with you?

---

9. What does the clinical teacher do for you that other staff do not do?

---

10. Can you suggest any things which clinical teachers do which you think they should not do?

---

11. Can you suggest any things which clinical teachers do not do which you would like them to do?

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree; 4 Agree; 3 Not Sure; 2 Disagree; 1 Strongly Disagree

12.	Clinical teachers tend to be rather rigid in their approach.	5	4	3	2	1
13.	Clinical teachers are not usually very understanding.	5	4	3	2	1
14.	Clinical teachers tend to be warm, friendly people.	5	4	3	2	1
15.	Clinical teachers tend to be rather ineffective.	5	4	3	2	1
16.	Clinical teachers try to create an informal, friendly atmosphere.	5	4	3	2	1
17.	The clinical teacher is much better at teaching nursing than the ward staff.	5	4	3	2	1
18.	Most clinical teachers go out of their way to help students.	5	4	3	2	1
19.	The clinical teacher never seems to be there when I need her.	5	4	3	2	1
20.	I feel free to ask the clinical teacher whenever I am not sure of anything.	5	4	3	2	1
21.	I feel inadequate when I am working with a clinical teacher.	5	4	3	2	1
22.	The clinical teacher is more helpful than the ward nurses.	5	4	3	2	1
23.	I would like more opportunity to work with a clinical teacher.	5	4	3	2	1
24.	Working with a clinical teacher makes me feel more confident.	5	4	3	2	1
25.	It is more satisfactory to go to ward staff for help than to the clinical teacher.	5	4	3	2	1
26.	The clinical teacher is not really sure of the ward routine.	5	4	3	2	1
27.	The clinical teacher goes over procedures but does not tell me what I really want to know.	5	4	3	2	1
28.	The clinical teacher is not as competent a nurse as the ward staff.	5	4	3	2	1
29.	Clinical teachers do not seem to be very well thought of by ward staff.	5	4	3	2	1
30.	Clinical teachers do not seem to very well thought of by tutors.	5	4	3	2	1

(e) Trained staff's questionnaire

CLINICAL TEACHING STUDY

Trained Staff No S

This questionnaire is about your experience of clinical teaching. Please read the statements 1 - 15 carefully and consider whether, from your experience of clinical teachers, you would agree or disagree with it.

Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase most closely expressing your opinion, i.e. 5 for 'Strongly agree', 4 for 'Agree', 3 for 'Not sure', 2 for 'Disagree' or 1 for 'Strongly disagree'.

When you have done that please answer questions 16 - 20 in the space provided.

I have arranged to collect the envelopes containing the questionnaire from the College of Nursing. When you have completed it, the questionnaire, which will be treated confidentially, should be sent to the college in the envelope provided.

Thank you for your help.

C M Robertson

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree; 4 Agree; 3 Not Sure; 2 Disagree; 1 Strongly Disagree

1.	Clinical teachers are running away from the real challenge of nursing.	5	4	3	2	1
2.	Having a clinical teacher in the ward raises the standard of nursing care.	5	4	3	2	1
3.	Clinical teachers have a wider, more lasting influence on learners than do ward staff.	5	4	3	2	1
4.	Clinical teachers are not on the whole very competent nurses.	5	4	3	2	1
5.	Ward staff are more essential to the teaching of nurses than clinical teachers.	5	4	3	2	1
6.	I would like the clinical teacher to come to the ward more often.	5	4	3	2	1
7.	Clinical teachers have a real contribution to make to ward teaching.	5	4	3	2	1
8.	Clinical teachers tend to interrupt ward work too much.	5	4	3	2	1
9.	Clinical teachers are not in the ward often enough to have any real impact on ward teaching.	5	4	3	2	1
10.	It is good to have a clinical teacher with a learner when we are very busy.	5	4	3	2	1
11.	The clinical teachers have a wider, more lasting influence on the learner than the tutors have.	5	4	3	2	1
12.	Clinical teachers are likely to be of more practical help to learners than are tutors.	5	4	3	2	1
13.	Clinical teacing is just a preparation for real teaching.	5	4	3	2	1
14.	Tutors have a more essential part in the teaching of nurses than clinical teachers have.	5	4	3	2	1
15.	The clinical teachers' theoretical knowledge is not as great as that of the tutors.	5	4	3	2	1
16.	Would you please circle the number opposite your grade					
		Enrolled nurse				1
		Staff nurse				2
		Sister/Charge nurse				3
17.	Hospital _____	Ward No _____				

18. Can you suggest any things which the clinical teacher does which you think he/she should not do?

---

19. Can you suggest any things which the clinical teacher does not do which you would like him/her to do?

---

20. Please indicate those aspects of the clinical teacher's job which you think are most helpful.

(f) Tutors' questionnaire

CLINICAL TEACHING STUDY

Tutor No T

Please read each of the statements overleaf carefully and consider whether, from your experience of clinical teachers, you would agree or disagree with it. Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase which most closely expresses your opinion, i.e. 5 for 'Strongly Agree'; 4 for 'Agree'; 3 for 'Not Sure'; 2 for 'Disagree' or 1 for 'Strongly disagree'.

Then please answer questions 12 and 13 in the space provided. The completed questionnaire, which will be treated confidentially, should be sent to the College of Nursing in the envelope provided.

Thank you for your help.

C M Robertson

Please circle the appropriate number for each statement according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

1.	Having clinical teachers in the wards raises the standard of nursing care.	5	4	3	2	1
2.	Clinical teachers have a wider, more lasting influence on learners than do ward staff.	5	4	3	2	1
3.	Ward staff are more essential to the teaching of nurses than clinical teachers are.	5	4	3	2	1
4.	Clinical teachers have a real contribution to make to ward teaching.	5	4	3	2	1
5.	Clinical teachers are not in the wards often enough to have any real impact.	5	4	3	2	1
6.	Having clinical teachers in the wards raises the standard of ward teaching.	5	4	3	2	1
7.	Clinical teachers should confine themselves to ward teaching.	5	4	3	2	1
8.	Clinical teachers should assist in the whole work of the school.	5	4	3	2	1
9.	Clinical teaching is a preparation for real teaching.	5	4	3	2	1
10.	The same person cannot combine classroom teaching and clinical teaching adequately.	5	4	3	2	1
11.	Ward teaching is more difficult than classroom teaching.	5	4	3	2	1

12. Can you suggest any things which clinical teachers do which you think they should not be doing?

13. Can you suggest any things which you think clinical teachers should be doing which they are not at present doing?

(g) Clinical Teachers' questionnaire

CLINICAL TEACHING STUDY

Clinical Teacher No C

Please read each of the following statements carefully and consider whether you would agree or disagree with it. Five possible degrees of agreement or disagreement are given. For each statement please circle the number which represents the phrase which most closely expresses your opinion, i.e. 5 for 'Strongly agree'; 4 for 'Agree'; 3 for 'Not sure'; 2 for 'Disagree' or 1 for 'Strongly disagree'.

I have arranged to collect the envelopes containing the questionnaires from the College of Nursing. When you have completed it, the questionnaire, which will be treated confidentially, should be sent to the college in the envelope provided.

Thank you for your help.

C M Robertson

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

1.	Ward staff think that the clinical teacher is running away from the real challenge of nursing.	5	4	3	2	1
2.	Learners would rather seek information and help from ward staff than from a clinical teacher.	5	4	3	2	1
3.	Learners find it difficult to think of the clinical teacher as really being a nurse.	5	4	3	2	1
4.	Ward staff see the clinical teacher as helping to raise the standard of nursing care.	5	4	3	2	1
5.	The clinical teacher has a wider, more lasting influence on the learner than the ward staff have.	5	4	3	2	1
6.	The clinical teacher's professional ability is questioned by ward staff.	5	4	3	2	1
7.	Learners would rather seek information and help from the tutors than from the clinical teacher.	5	4	3	2	1
8.	The clinical teacher has a wider, more lasting influence on the learner than the tutors have.	5	4	3	2	1
9.	Ward staff have a more essential part in the teaching of nurses than the clinical teacher has.	5	4	3	2	1
10.	Tutors have a more essential part in the teaching of nurses than clinical teachers have.	5	4	3	2	1
11.	I do not have much say or influence with ward staff.	5	4	3	2	1
12.	I do not have much say or influence with teaching staff.	5	4	3	2	1
13.	My general programme of teaching is controlled by the school.	5	4	3	2	1
14.	The tutors indicate which learners should be given most clinical teaching.	5	4	3	2	1
15.	The tutors know what pattern of clinical teaching is needed and I fit in with it.	5	4	3	2	1
16.	The tutors arrange my college commitments and ward teaching is fitted round them.	5	4	3	2	1
17.	In order to plan my teaching I discuss the needs of the learners with the tutors.	5	4	3	2	1
18.	I am free to plan my work as I think fit.	5	4	3	2	1
19.	I decide my general teaching programme and keep the tutors informed.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagre

20.	I just get on with ward teaching without any guidance from the tutors.	5	4	3	2	1
21.	Sister tells me which learners need help and I work with them.	5	4	3	2	1
22.	The ward sister allocates the work and I just fit in.	5	4	3	2	1
23.	I do things the way the ward sister says she likes them done.	5	4	3	2	1
24.	The ward staff expect me to teach certain things but I would like to be able to develop my own teaching pattern.	5	4	3	2	1
25.	I let sister know what I want to do and with which learner I want to work.	5	4	3	2	1
26.	I plan my teaching ahead so that the ward staff can make the necessary arrangements.	5	4	3	2	1
27.	I teach in the way I think best even though the ward staff think I should do it differently.	5	4	3	2	1
28.	I feel free to discuss with sister anything in the ward which I feel could be improved.	5	4	3	2	1
29.	Sister and I plan the ward teaching together.	5	4	3	2	1
30.	I find that I am very tied to routine tasks.	5	4	3	2	1
31.	I do not have as much control over my own work as I would like to have.	5	4	3	2	1
32.	I have plenty of opportunity to use my own initiative.	5	4	3	2	1
33.	Considering my job as a whole I am satisfied with it.	5	4	3	2	1
34.	I find the job frustrating.	5	4	3	2	1
35.	Contact with the learners compensates for this frustration.	5	4	3	2	1
36.	Contact with patients compensates for this frustration.	5	4	3	2	1
37.	The tutors have definite ideas about clinical teaching which I find it difficult to change.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagree

38.	On the whole, I think this college of nursing is a good place to work.	5	4	3	2	1
39.	I have to do some things in the clinical areas that I would rather do differently.	5	4	3	2	1
40.	The ward staff have definite ideas about clinical teaching which I find it difficult to change.	5	4	3	2	1
41.	On the whole, I think this hospital is a good place to work.	5	4	3	2	1
42.	The way the wards are organised makes it impossible for me to teach in the way that I would like to.	5	4	3	2	1
43.	I feel unsure about how much authority I have in the clinical area.	5	4	3	2	1
44.	I do things that are apt to be accepted by one person and not by others.	5	4	3	2	1
45.	I am uncertain just what the scope and responsibilities of the job are.	5	4	3	2	1
46.	I find it difficult to get the information I need to do the job properly.	5	4	3	2	1
47.	I cannot satisfy anyone in this job.	5	4	3	2	1
48.	I know exactly what the people I work with expect of me.	5	4	3	2	1
49.	I receive incompatible requests from various people.	5	4	3	2	1
50.	I would like to leave clinical teaching if I could.	5	4	3	2	1
51.	Clinical teaching is a rather lonely job.	5	4	3	2	1
52.	There is not much contact between clinical teachers and tutors.	5	4	3	2	1
53.	Now that I am a clinical teacher I don't feel that I am part of the hospital to the same extent as I used to.	5	4	3	2	1
54.	Although I am no longer part of the ward staff I still have satisfying contacts with patients.	5	4	3	2	1
55.	Now that I am a clinical teacher I don't have as much contact with medical staff as I would like.	5	4	3	2	1
56.	A clinical teacher can still function as part of the clinical team.	5	4	3	2	1

Please circle the appropriate number for each statement, according to the following code:

5 Strongly Agree 4 Agree 3 Not Sure 2 Disagree 1 Strongly Disagre

57.	Out of working hours I have close contacts with some members of the ward staff.	5	4	3	2	1
58.	Out of working hours I have close contacts with some members of the teaching staff.	5	4	3	2	1
59.	I do not get much support from the nurse tutors.	5	4	3	2	1
60.	The clinical teachers and the tutors work well together.	5	4	3	2	1
61.	The clinical teachers don't really work as part of the teaching team.	5	4	3	2	1
62.	Tutors have a real contribution to make to ward teaching.	5	4	3	2	1
63.	Tutors should confine themselves to classroom teaching.	5	4	3	2	1
64.	Clinical teachers should confine themselves to ward teaching.	5	4	3	2	1
65.	Clinical teachers should assist in the whole work of the school.	5	4	3	2	1
66.	Clinical teaching is a preparation for real teaching.	5	4	3	2	1
67.	The same person cannot combine classroom teaching and ward teaching adequately.	5	4	3	2	1
68.	Ward teaching is more difficult than classroom teaching.	5	4	3	2	1

(h) Clinical Teachers' interview schedule

CLINICAL TEACHING STUDY

NAME ..... MARITAL STATUS .....

COLLEGE .....

TRAVELLING TIME TO WORK .....

CODE NUMBER ..... CHILDREN/DEPENDANTS .....

PRESENT POST ..... LENGTH OF TIME IN POST .....

YEAR OF CLINICAL TEACHER COURSE .....

CENTRE AT WHICH COURSE WAS TAKEN .....

DID YOU HAVE ANY CONTACT WITH A CLINICAL TEACHER DURING YOUR OWN

NURSE TRAINING? YES/NO BASIC .....

POSTREGISTRATION .....

PAST EXPERIENCE

LENGTH OF SERVICE IN THIS HOSPITAL

1. Is your allocation to:

   (a) specific clinical areas;

   (b) groups of learners;

   (c) both.

2. If your allocation is specific to clinical areas, how many wards or sections do you cover?

3. How were these areas selected?

   (a) geographically?

   (b) by specialty?

   (c) other, specify.

4. Were you involved in the selection?

   (a) Yes;

   (b) No.

5. If your allocation is to groups of learners, how many learners are specifically allocated to you?

6. Do you go with learners to:

   (a) all clinical areas;

   (b) selected areas only.

7. If you go to selected areas only, how are these areas selected?

   (a) geographically;

   (b) by specialty;

   (c) other, specify.

8. Were you involed in selecting the areas?

   (a) Yes;

   (b) No.

9. Are the clinical areas to which you are allocated, or in which you regularly teach, situated:

   (a) on the same site as the college of nursing;

   (b) on a different site from the college but all on the same site;

   (c) on different sites from each other and from the college;

   (d) some on the same site as the college and some on a different one.

10. During the last week approximately how much of your time was spent travelling between clinical areas and the college of nursing?

11. Do you have office accommodation near the clinical areas in which you regularly work?

   (a) yes, near all of them;

   (b) near some of them only;

   (c) no.

12. Do you have office accommodation at the college of nursing?

   (a) Yes;

   (b) No.

13. If your allocation is to a clinical area which specialty or specialties does that include?

14. Were you given a choice of clinical areas?

    (a) Yes;

    (b) No.

15. What span of duty do you normally cover?

16. Do you ever work with learners in the evenings?

    on night duty?

    at weekends?

    If not, can you see any advantages in doing so?

    Are there any particular reasons why you do not work at these times?

17. What hours did you cover?

    Why?

18. Did you find this satisfactory?

    Why?

19. Do you work with:

    (a) all kinds of learners;

    (b) selected groups of learners, specify.

20. What is the maximum number of "your" learners on duty at any one time this week?

21. What is the minimum number of "your" learners on duty at any one time this week?

22. How do you decide how your time should be divided between wards/ sections?

23. How do you decide which students/pupils will receive clinical teaching?

    (a) random choice/availability;

    (b) attempt to see every student;

    (c) specific stages in training;

    (d) those who most seem to need it;

    (e) those who seem most to want it;

    (f) opinion of other staff taken into account.

24. Do you try to plan your day's work in advance?

25. To what extent is it possible to plan more than one day ahead?

26. Can you rank these activities in order of the amount of time which you spend on each, giving (1) to the one which you do most often and on which you spend most time, and (5) to the one which you do least often and on when you spend least time?

    (a) carry out specific procedures with particular students;

    (b) work with one student to complete the tasks which have been allocated to her or to you both;

    (c) care for the individual patients with a student;

    (d) take group of students together to discuss specific topics;

    (e) discuss specific topics with individual students.

27. How do you find out what has been happening to the patients from day to day?

28. How would you rate the job satisfaction gained from ward based teaching?

(a) very high;

(b) high;

(c) fair;

(d) low;

(e) very low.

29. Approximately how much time did you spend last week on:

(a) arranging ward teaching;

(b) record keeping;

(c) ad hoc meetings/discussions with ward staff;

(d) ad hoc meetings/discussions with tutorial staff;

(e) ad hoc meetings/discussions with others, specify;

(f) teaching in the practical/demonstration room;

(g) informal counselling;

(h) in-service training;

(i) formal assessment;

(j) committees;

(k) preparation (including reading to keep up to date);

(l) other activities, specify.

30. Approximately how much of your time during the past week was spent on teaching in the classroom?

31. How does this compare with an "average" week? Do you normally teach in this situation?

(a) more;

(b) about the same time;

(c) less.

32. How many times a year does this commitment involve you in this way?

(a) once;

(b) twice;

(c) three times;

(d) four times;

(e) more than four times, please specify.

33. Does this teaching form part of a regular commitment to a specific:

(a) subject;

(b) study block;

(c) group of students.

34. How would you rate the job satisfaction gained from non-ward based teaching?

(a) very high;

(b) high;

(c) fair;

(d) low;

(e) very low.

35. How does your senior tutor monitor your work?

36. Which of the following statements most nearly expresses your feelings about the job as a whole?

(a) I am very satisfied with it;

(b) it is not ideal but I will probably stick to it for some time to come;

(c) it is not ideal and I will probably go on to something else in the near future;

(d) it is unsatisfactory and I will get out as soon as I can;

(e) it is fairly satisfactory but I expect to move on to something else in due course.

37. What do you think you might go on to next?

38. What do you see as the particular problems of this job?

39. What are its principal attractions?

(i) Principal Tutor's Interview Schedule

CLINICAL TEACHING STUDY

Code No.T

1. Name of College of Nursing.

2. Types of trianing offered

3. Numbers of Learners

4. Number of tutors in post:-

D.N.E.

Senior Tutors

Tutors

5. Number of clinical teachers in post:- full time? part time?

Organisation of Clinical Teaching

6. Are the clinical teachers allocated to:

specific clinical areas? how were these selected?

how many learners are there on average?

how much choice did the C.T. have?

specific groups of learners? how many in each group?

7. What hours do the clinical teachers work?

8. Do they ever work with learners in the evenings?

during the night?

at weekends?

if not, why not?

if so, on what kind of occasion?

Whose decision would this be?

Planning and implementation of clinical teaching

9. How would you expect a clinical teacher to decide how her time should be divided between wards/sections?

10. How would you expect a clinical teacher to decide which students/pupils should receive clinical teaching?

    (a) random choice/availability?

    (b) attempt to see every student?

    (c) see those at specific stages of training?

    (d) see those who most need it?

    (e) see those who most seem to want it?

11. Are there any learning objectives prepared for the wards?

12. By whom were they prepared?

13. Roughly how much time would you expect a clinical teacher to spend on each of these activities in a week?

    (a) arranging ward teaching;

    (b) record keeping;

    (c) discussions with ward staff;

    (d) discussions with tutorial staff;

    (e) discussions with others;

    (f) teaching in the practical/demonstration room;

    (g) informal counselling;

    (h) in-service training;

    (i) formal assessments;

    (j) committees;

    (k) preparation (including reading to keep up to date);

    (l) other activities.

14. Can you rank these activities in order of the amount of weight your clinical teachers put on them?

    (a) carrying out specific procedures with particular learners;

    (b) working with one learner to complete the tasks allocated to her;

    (c) caring for individual patients with a learner;

    (d) taking groups of learners together to discuss specific topics;

    (e) discussing specific topics with individual learners;

    Now can you rank them in the order in which you would like your clinical teachers to weight them?

15. How do you keep yourself informed about what the clinical teachers are doing?

16. What kind of control do you have of the clinical teaching?

17. Approximately how much classroom teaching do the clinical teachers do?

18. Is this a regular commitment to: specific subjects?

    a group of learners?

19. Do you expect the clinical teachers to be accepted by the ward staff as part of the ward team?

20. How can this be achieved?

21. How much contact do they have with the tutors?

22. What kind of support do the clinical teachers need?

23. How can this be provided?

24. How much freedom do the clinical teachers have to plan and organise their teaching for themselves?

Appendix 3

Job descriptions

1-6

JOB DESCRIPTION 1

ROLE:	CLINICAL TEACHER
GRADE:	WARD SISTER
RESPONSIBLE TO:	DIRECTOR OF NURSE EDUCATION
REPORTS TO:	SENIOR NURSE TUTOR
MINIMUM QUALIFICATIONS:	REGISTERED NURSE WITH TWO YEARS POST-REGISTRATION EXPERIENCE. EITHER POST-REGISTRATION COURSE IN CLINICAL TEACHING OR DIPLOMA OF NURSING PART 'A'.

FUNCTIONS:

A. Professional

1. Instructing student/pupil nurses in application of nursing practice to theoretical knowledge giving total patient care in specified ward/unit to comply with the Educational Programme.

2. Inducting new students to ward/unit.

3.1 Demonstrating nursing procedures in the clinical situation.

3.2 Taking part in classroom instruction of students in practical procedures in Introductory Course and thereafter only in own speciality when required.

4. Supervising students executing procedures demonstrated.

5. Preparing and presenting material to students according to clinical material available in the ward/unit.

6. Participating in In-Service training.

7. Assisting with statutory assessments.

8. Participating as a member of the
   a) Education Division Meetings,
   b) Area Meetings,
   c) Nursing Service Meetings,
   d) Meetings of Assessors.

9. Participating in the programme for Student Clinical Teachers and Pupil Teachers.

10. To be prepared to assist in Casualty at a Major Accident Alert.

B. Administration

11. Planning teaching programmes with the ward/unit in conjunction with the Ward Sister, Nursing Officer and Tutor.

12.1 Keeping records of students in the ward/unit and transferring the information to the School of Nursing record of instruction at the completion of each experience.

12.2 Recording hours of teaching for each student at the end of Introductory Course and each Set's year and recording in the Kardex.

13. Reporting to the Senior Tutor the effects of the teaching policy and the results of the teaching programme.

C. Personnel

14. Discussing clinical progress with the Ward Sister, and where possible in conjunction with the Ward Sister, giving merit rating according to the established procedure.

15. Counselling the students in the ward/unit.

16. Reporting on students to the unit nursing officer and to the Senior Nursing Officer (Education).

JOB DESCRIPTION 2

Responsible to: Principal Nursing Officer

Reports to: Principal Nursing Officer

Minimum qualifications: Registered general nurse
Experience as a staff nurse
Post-registration course in clinical teaching
Nurse who is prepared to undertake secondment to clinical teaching course

Duties

Professional

1. To instruct student and pupil nurses in bedside nursing and observation of the patient.

2. To liaise with the charge nurse and tutor in the organisation of clinical rounds in accordance with the programme.

3. To keep abreast of all medical equipment.

4. To participate in in-service training.

5. To assist with hospital examinations and tests.

6. To participate in forming nursing procedures.

Administrative

7. To keep records of student and pupil nurses in the unit.

8. To counsel student and pupil nurses in the unit.

9. To attend weekly meetings, and report on student and pupil nurses to the Principal Nursing Officer.

JOB DESCRIPTION 3

ROLE: Teacher of learner nurses in the clinical situation and in educational establishments.

GRADE: Clinical Teacher

RESPONSIBLE TO: Senior Nursing Officer (Education)

REPORTS TO: Senior Nursing Officer (Education)

FUNCTIONS:

In accordance with Health Board and Educational Committee Policy the Clinical Teacher in liaison with Charge Nurses is responsible for organising nursing education for learner nurses in the situation in which nursing care is either directly/indirectly provided. By effective and continuous leadership, through attitude, ability to teach and availability to staff the Clinical Teacher is able to organise, plan and direct activities so that optimal skills and expertise may be acquired, satisfaction achieved and a climate for learning created.

A. PROFESSIONAL

1. To co-operate with the Charge Nurses and Nursing Officers in Maintaining the highest standard of patient care.
2. To act as liaison between service and education divisions.
3. To attend clinical rounds and unit meetings (when necessary) thus keeping up to date with patient progress and unit policy respectively.
4. To ensure there is a degree of uniformity in basic nursing principles.
5. To participate in the continuing assessment of learners.
6. To co-operate with the Charge Nurse and Nursing Officer in the instruction of learner nurses. The Charge Nurse and the Clinical Teacher will work as a team constructing teaching programmes.
7. To co-operate with the Charge Nurses and the Nursing Officer to ensure that teaching programmes are geared to the learners' stage of training.
8. To assist with "in service" education for staff. This is an additional commitment and cannot be undertaken at the expense of learner education.
9. To encourage senior learners in the clinical situation to accept a teaching role with regard to junior learners - and to give advice when required.
10. To create a sensitivity in learners to patient's needs and encouraging recognition of the patient as an individual.
11. To encourage and utilise observations and suggestions of learners in planning and promoting the improvement of patient care.

B. ADMINISTRATIVE

1. To arrange clinical teaching for student/pupil nurses in consultation with Charge Nurses, Medical Staff and others.
2. To report to the Senior Tutor and the Director of Nurse Education the possible effects of teaching policy and the results of the teaching programme.

3. To maintain record of learner nurses working within the unit.
4. To arrange in co-operation with service and teaching personnel the contents and programming of specific theoretical modules.
   e.g. Premodular programmes (applicable to the area)
   Experimental programmes for pre-nursing colleges
   Experimental programmes for Clinical Teacher students

PERSONNEL

1. To make time available to act as counsellor/advisor to learner nurses.
2. To guide and support learner nurses in developing leadership skills.
3. To take all steps possible to safeguard the welfare and safety of learner nurses while they are in training.
4. To establish good personal relationships with learner nurses.
5. To discuss the clinical progress of learner nurses with Charge Nurses and Nursing Officers.
6. To report on learner nurses to the senior tutor.
7. To participate in interviews for prospective learner nurses.